State of Indiana

Trauma Registry Data Dictionary

2015

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*** Indicates National and/or State required elements**

Indiana Inclusion/Exclusion Criteria

Definition:

To ensure consistent data collection across the State and with the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

The patient must have incurred, no more than 30 days prior to presentation for initial treatment, at least one of the following injury diagnostic codes defined as follows:

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM):800–959.9

International Classification of Diseases, Tenth Revision (ICD-10-CM):

S00-S99 with 7th character modifiers of A,B, or C ONLY. (Injuries to specific body parts – initial encounter)
T07 (unspecified multiple injuries)
T14 (injury of unspecified body region)
T20-T28 with 7th character modifier of A ONLY (burns by specific body parts – initial encounter)
T30-T32 (burn by TBSA percentages)
T79.A1-T79.A9 with 7th character modifier of A ONLY *(Traumatic Compartment Syndrome – initial encounter)*

Excluding the following isolated injuries:

ICD-9-CM:

905-909.9 (late effects of injury)
910-924.9 (superficial injuries: blisters, contusions, abrasions, Insect bites) 930-939.9 (foreign bodies – ingested, eye, etc.)

ICD-10-CM:

S00 (*Superficial injuries of the head)*
S10 *(Superficial injuries of the neck)*
S20 *(Superficial injuries of the thorax)*
S30 *(Superficial injuries of the abdomen, pelvis, lower back and external genitals)*
S40 *(Superficial injuries of shoulder and upper arm)*
S50 *(Superficial injuries of elbow and forearm)*
S60 *(Superficial injuries of wrist, hand and fingers)*
S70 *(Superficial injuries of hip and thigh)*
S80 *(Superficial injuries of knee and lower leg)*
S90 *(Superficial injuries of ankle, foot, and toes)*

Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.

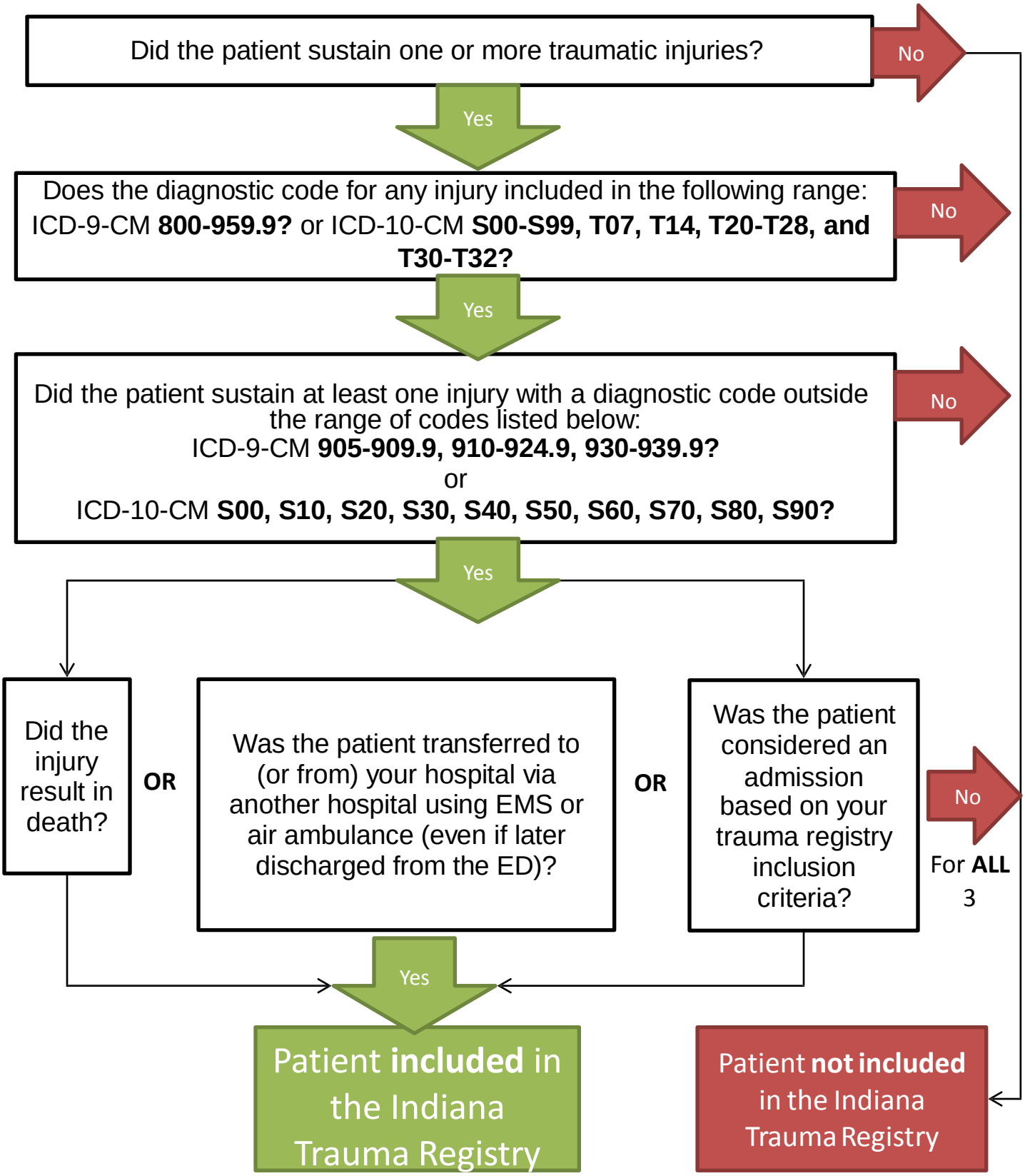
AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO (ICD-9-CM 800-959.9 OR ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9):

- Hospital admission as defined by your trauma registry inclusion criteria **OR:**
- Patient transfers via EMS transport (including Air Ambulance) from one hospital to another

hospital (even if later discharged from the ED) **OR:**

- Death resulting from the traumatic injury (independent of hospital admission or transfer status)

Indiana Trauma Registry Inclusion Criteria Map



National & State Element

COMMON NULL VALUES

Data Format	[combo] single-choice

Definition

These values are to be used with each of the National Trauma Data Standard Data Elements and Indiana Trauma Data Standard Data Elements described in this document which have been defined to accept the Null Values.

Field Values

1 Not Applicable
2 Not Known / Not Recorded

Additional Information

- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the National Trauma Data Standard and Indiana Trauma Data Standard are to be electronically stored in a database or moved from one database to another using XML, the indicated null values should be applied

- Not Applicable (NA): This null value code applies if, at the time of patient care documentation, the information requested was "Not Applicable" to the patient, the hospitalization, or the patient care event. For example, variables documenting EMS care would be "Not Applicable" if a patient self-transports to the hospital.

- Not Known / Not Recorded (NK / NR): This null value applies if, at the time of patient care documentation, information was "Not Known" (to the patient, family, or health care provider) or no value for the element recorded for the patient. This documents that there was an attempt to obtain information but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as "Unknown". Another example, Not Known/Not Recorded should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).

Demographic Information

Optional State Element **TR 1.2**

MEDICAL RECORD # *

Data Format [text]

Definition

The hospital's medical record number for the patient

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes
Required in XSD	No	**Min. Constraint:**	**Max. Constraint:**

Field Values

- Relevant value for data element

Additional Information

- Auto-generated by the hospital

Optional State Element **TR 1.27**

Account # *

Data Format [text]

Definition

The hospital's encounter number for the patient that is unique to this visit.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes
Required in XSD	No	**Min. Constraint:**	**Max. Constraint:**

Field Values

- Relevant value for data element

Additional Information

- Auto-generated by the hospital

INJURY INCIDENT DATE *

Data Format [date]

Definition

The date the injury occurred.

XSD Data Type	*xs: date*	**XSD Element / Domain (Simple Type)**	*IncidentDate*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1,990	**Max. Constraint:** 2,030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Estimates of date of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used
- If date of injury is "Not recorded / Not known", the null value is unknown

Data Source

- EMS Run Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Face Sheet

National Element

- National Element I_01 from the 2015 National Trauma Data Standard

National & State Element

TR 5.18

INJURY INCIDENT TIME *

Data Format [time]

Definition

The time the injury occurred.

XSD Data Type	*xs: time*	**XSD Element / Domain (Simple Type)**	*Incident Time*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used
- If time of injury is "Not recorded / Not known", the null value is unknown

Data Source

- EMS Run Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Face Sheet

National Element

- National Element I_02 from the 2015 National Trauma Data Standard

Optional State Element **TR 1.9**

PATIENT'S LAST NAME

Data Format [text]

Definition

The patient's last name.

XSD Data Type	*xs: text*	**XSD Element / Domain (Simple Type)**	*LastName*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Face Sheet
- EMS Run Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

Optional State Element **TR 1.8**

PATIENT'S FIRST NAME

Data Format [text]

Definition

The patient's first name.

XSD Data Type	*xs: text*	**XSD Element / Domain (Simple Type)**	*FirstName*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Face Sheet
- EMS Run Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

Optional State Element **TR 1.10**

PATIENT'S MIDDLE INITIAL

Data Format [text]

Definition

The patient's middle initial

XSD Data Type	*xs: text*	**XSD Element / Domain (Simple Type)**	*MiddleInitial*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Face Sheet
- EMS Run Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

TR 1.11

PATIENT'S SOCIAL SECURITY

Data Format [number]

Definition

The patient's social security number

XSD Data Type	*xs: number*	**XSD Element / Domain (Simple Type)**	*SocialSecurityNumber*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as ###-##-#####

Data Source

- Face Sheet
- EMS Run Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

DATE OF BIRTH *

Data Format [date]

Definition

The patient's date of birth.

XSD Data Type *xs: date*		**XSD Element / Domain (Simple Type)**	*DateOfBirth*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1,890	**Max. Constraint:** 2,030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- If date of birth is equal to the ED/Hospital Arrival date, then the Age & Age Units variables must be completed
- If date of birth is "Not Recorded / Not Known" complete variables: Age and Age Units
- Used to calculate patient age in days, months, or years

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_07 from the 2015 National Trauma Data Standard

AGE *

Data Format [number]

Definition

The patient's age at the time of injury (best approximation)

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Age*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 120

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated to patient's age in years when "Date of Birth" is entered
- Used to calculate patient age in hours, days, months, or years
- If date of birth is equal to the ED/Hospital Arrival date, then the Age & Age Units variables must be completed
- If date of birth is "Not Recorded / Not Known" complete variables: Age and Age Units
- Must also complete variable: Age Units

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_08 from the 2015 National Trauma Data Standard

AGE UNITS*

Data Format [combo] single-choice

Definition

The units used to document the patient's age (Years, Months, Days, Hours)

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AgeUnits*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1	Hours	3	Months
2	Days	4	Years

Additional Information

- Used to calculate patient age in hours, days, months, or years
- If date of birth is equal to the ED/Hospital Arrival date, then the Age & Age Units variables must be completed
- If date of birth is "Not Recorded / Not Known" complete variables: Age and Age Units
- Must also complete variable: Age

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form/Trauma Flow Sheet
- EMS Run Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_09 from the 2015 National Trauma Data Standard

National & State Element

RACE*

Data Format [combo]multiple-choice

Definition

The patient's race.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Race*
Multiple Entry Configuration	Yes, max 2	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Asian
2 Native Hawaiian or Other Pacific Islander
3 Other Race
4 American Indian
5 Black or African American
6 White

Additional Information

- Patient race should be based upon self-report or identified by a family member
- Maximum number of races that may be reported for an individual patient is two

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form/Trauma Flow Sheet
- EMS Run Sheet
- ED Nurses' Notes
- Face Sheet
- History & Physical

National Element

- National Element D_10 from the 2015 National Trauma Data Standard

OTHER RACE

Data Format [text]

Definition

The patient's secondary race (if the first race field is insufficient)

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

Patient race should be based upon self-report or identified by a family
- member
- Only completed if Race is "Other Race"

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- ED Admission Form
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes

ETHNICITY*

Data Format [combo] single-choice

Definition

The patient's ethnicity.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Ethnicity*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Hispanic or Latino 2 Not Hispanic or Latino

Additional Information

- Patient ethnicity should be based upon self-report or identified by a family member
- The maximum number of ethnicities that may be reported for an individual patient is 1

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- Triage Form/Trauma Flow Sheet
- EMS Run Sheet
- ED Nurses' Notes
- Face Sheet
- History & Physical

National Element

- National Element D_11 from the 2015 National Trauma Data Standard

GENDER*

Data Format [combo] single-choice

Definition

The patient's gender

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Sex*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Male 2 Female

Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet
- History & Physical

National Element

- National Element D_12 from the 2015 National Trauma Data Standard

National & State Element **TR1.6.1**

Height* (cm)

Data Format [combo] single-choice

Definition

First recorded height upon ED/hospital arrival.

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *Height*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 244 (cm)

Field Values

- Relevant value for data element

Additional Information

- Recorded in centimeters
- May be based on family or self-report
- Please note that the first recorded hospital vitals do not need to be from the same assessment
- Used to auto-generate an additional calculated field: Height (inches)

Data Source

- Triage Form / Trauma Flow Sheet
- ED Record
- EMS Run Sheet
- Nurses notes
- Self-report
- Family report
- Other ED documentation
- Pharmacy Record

National Element

- National Element ED_15 from the 2015 National Trauma Data Standard

National & State Element **TR1.6.5**

Weight* (kg)

Data Format [combo] single-choice

Definition

Measured or estimated baseline weight.

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *Weight*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 907 (kg)

Field Values

- Relevant value for data element

Additional Information

- Recorded in kilograms
- May be based on family or self-report
- Used to auto-generate an additional calculated field: Weight (pounds)
- Please note that first recorded/hospital visits do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- ED Record
- EMS Run Sheet
- Nurses notes
- Self-report
- Family report
- Other ED documentation
- Pharmacy Record

National Element

- National Element ED_16 from the 2015 National Trauma Data Standard

TR 1.18

PATIENT'S HOME ADDRESS

Data Format [text]

Definition

The home street address of the patient's primary residence.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Face Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Admission Form
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes

National & State Element

TR 1.19

PATIENT'S HOME COUNTRY*

Data Format [combo] single-choice

Definition

The country where the patient resides.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*HomeCountry*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element

Additional Information

- When completed with ZIP code, city, county, and state auto-calculate

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- ED Admission Form
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_02 from the 2015 National Trauma Data Standard

PATIENT'S HOME ZIP CODE*

Data Format [text]

Definition

The patient's ZIP code of primary residence.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*HomeZip*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element

Additional Information

- May require adherence to HIPAA regulations
- Stored as a 5 digit code
- When completed with Country the city, county, and state auto-calculate
- If ZIP code is "Not Applicable", complete variable: Alternate Home Residence
- If ZIP code is "Not Recorded / Not Known", complete variables: Patient's Home State ; Patient's Home County; Patient's Home City
- If ZIP code is left blank, Patient's Home City, County, and State defaults to "Not Applicable"

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- ED Admission Form
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_01 from the 2015 National Trauma Data Standard

PATIENT'S HOME CITY*

Data Format [combo] single-choice

Definition

The patient's city (or township, or village) of residence.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*HomeCity*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element (five digit FIPS code)

Additional Information

- Auto-Calculated if ZIP code and Country are completed
- Only complete when ZIP code is "Not Recorded / Not Known"
- Used to calculate FIPS code

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_05 from the 2015 National Trauma Data Standard

PATIENT'S HOME COUNTY*

Data Format [combo] single-choice

Definition

The patient's county (or parish) of residence.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*HomeCounty*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element (three digit FIPS code)

Additional Information

- Auto-Calculated if ZIP code and Country are completed
- Only complete when ZIP code is "Not Recorded / Not Known"
- Used to calculate FIPS code

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- ED Admission Form
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_04 from the 2015 National Trauma Data Standard

PATIENT'S HOME STATE*

Data Format [combo] single-choice

Definition

The state (territory, province, or District of Columbia) where the patient resides.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*HomeState*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element (two digit numeric FIPS code)

Additional Information

- Auto-Calculated if ZIP code and Country are completed
- Only complete when ZIP code is "Not Recorded / Not Known"
- Used to calculate FIPS code

Data Source

- ED Admission Form
- Billing Sheet / Medical Records Coding Summary Sheet
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_03 from the 2015 National Trauma Data Standard

National & State Element

PATIENT'S ALTERNATE RESIDENCE*

Data Format [combo] single-choice

Definition

Documentation of the type of patient without a home zip code.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*HomeResidence*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Homeless
2 Undocumented Citizen
3 Migrant Worker
4 Foreign Visitor

Additional Information

- Only complete when ZIP code is "Not Applicable"
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters
- Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission
- Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country
- Foreign Visitor is defined as any person legally visiting a country other than his/her usual place of residence for any reason

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- ED Admission Form
- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Face Sheet

National Element

- National Element D_06 from the 2015 National Trauma Data Standard

InjuryInformation

National & State Element

ICD-9 LOCATION E-CODE*

Data Format [number]

Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (E 849.X).

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*LocationEcode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 9

Field Values

- Relevant ICD-9-CM code value for injury location

0 Home
1 Farm
2 Mine
3 Industry
4 Recreation
5 Street
6 Public Building
7 Residential Institution
8 Other
9 Unspecified

Additional Information

- ICD-9-CM Codes will be accepted for ICD-9 Location E-Code

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Progress Notes

National Element

- National Element I_08 from the 2015 National Trauma Data Standard

National Element

TR200.5

ICD-10 LOCATION E-CODE*

Data Format [number]

Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x).

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*PlaceOfInjuryCode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant ICD-10-CM code value for injury location

Additional Information

- Only ICD-10-CM codes will be accepted for ICD-10 Location E-Code

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Progress Notes

National Element

- National Element I_09 from the 2015 National Trauma Data Standard

National & State Element

INCIDENT LOCATION ZIP CODE*

Data Format [text]

Definition

The ZIP code of the incident location.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*InjuryZip*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element

Additional Information

- Stored as a 5 digit code
- When completed with Country, the city, county, and state auto-calculate
- If "Not Applicable", or "Not Recorded / Not Known" complete variables: Incident State, Incident County, Incident City and Incident Country.
- May require adherence to HIPAA regulations
  If ZIP code is left blank, Incident City, County, & State defaults to "Not
- Applicable"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National Element

- National Element I_12 from the 2015 National Trauma Data Standard

National & State Element

INCIDENT COUNTRY*

Data Format [combo] single-choice

Definition

The country where the patient was found or to which the unit responded (or best approximation).

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*IncidentCountry*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable" or "Not Recorded / Not Known"
- When completed with Zip Code, the city, county, and state auto-calculate

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National Element

- National Element I_13 from the 2015 National Trauma Data Standard

INCIDENT CITY*

Data Format [combo] single-choice

Definition

The city or township where the patient was found or to which the unit responded (or best approximation).

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*IncidentCity*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element (five digit FIPS code)

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Recorded / Not Known"
- Auto-Calculated if ZIP code and Country are completed
- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National Element

- National Element I_16 from the 2015 National Trauma Data Standard

INCIDENT COUNTY*

Data Format [combo] single-choice

Definition

The county or parish where the patient was found or to which the unit responded (or best approximation).

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*IncidentCounty*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element (three digit FIPS code)

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Recorded / Not Known"
- Auto-Calculated if ZIP code and Country are completed
- Used to calculate FIPS code

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National Element

- National Element I_15 from the 2015 National Trauma Data Standard

INCIDENT STATE*

Data Format [combo] single-choice

Definition

The state, territory, or province where the patient was found or to which the unit responded (or best approximation).

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*IncidentState*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant value for data element (two digit FIPS code)

Additional Information

- Only complete when Incident Location Zip Code is "Not Applicable", or "Not Recorded / Not Known"
- Auto-Calculated if ZIP code and Country are completed
- Used to calculate FIPS code

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National Element

- National Element I_14 from the 2015 National Trauma Data Standard

(Complaint) Supplemental Cause of Injury

Data Format [combo] single-choice

Definition

The event that occurred to cause injury to the patient

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Accident
- Aircraft
- All-Terrain Vehicle
- Assault
- Bicycle Crash
- Boating
- Burn
- Child Abuse
- Cut/Pierce
- Dirt Bike
- Diving
- Domestic Abuse
- Drowning
- Electrical Injury
- Fall
- Farm/Heavy
- Equipment/Machine
- Fire
- Fireworks Related
- Frostbite
- Gunshot Wound
- Hanging
- Heat Related
- Industrial Incident
- Injured by Animal
- Jet Ski
- Lightning
- Motor Pedestrian Crash
- Motor Vehicle Crash
- Motorcycle Crash
- Police
- Rape
- Recreational
- Rollerblading
- Rollerskating
- Scooter
- Skateboarding
- Skydiving
- Sledding
- Snowboarding
- Snowmobile
- Sport Related
- Stab Wound
- Struck By / Against
- Tornado
- Train
- Waterskiing

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

INJURY DESCRIPTION

Data Format [text]

Definition

The description of the injury. This can be any supporting or supplemental data about the injury, other circumstances, etc.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- History & Physical Documentation
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National & State Element

ICD-9 PRIMARY E-CODE*

Data Format [number]

Definition

External cause code used to describe the mechanism (or external factor) that caused the injury event.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*PrimaryEcode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant ICD-9-CM code value for injury event

Additional Information

- The Primary external cause code (E-Code) should describe the main reason a patient is admitted to the hospital
- E-codes are used to auto-generate two calculated fields: Trauma Type: (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- ICD-9-CM Codes will be accepted for this data element. Activity codes should not be reported in this field.

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Progress Report

National Element

- National Element I_06 from the 2015 National Trauma Data Standard

National Element

TR200.3

ICD-10 PRIMARY E-CODE*

Data Format [number]

Definition

External cause code used to describe the mechanism (or external factor) that caused the injury event.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*PrimaryECodeIcd10*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- The Primary external cause code (E-Code) should describe the main reason a patient is admitted to the hospital
- E-codes are used to auto-generate two calculated fields: Trauma Type: (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- ICD-10-CM Codes will be accepted for this data element. Activity codes should not be reported in this field.

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Progress Notes

National Element

- National Element I_07 from the 2015 National Trauma Data Standard

National & State Element

TR 20.2

ICD-9 ADDITIONAL E-CODE*

Data Format [number]

Definition

Additional external cause code used in conjuction with the primary E-Code if multiple external cause codes are required to describe the injury event.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*AdditionalECode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant ICD-9-CM code value for injury event

Additional Information

- External cause codes (E-Codes) are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- Only ICD-9-CM Codes will be accepted for additional ICD-9 E-Code.
- Activity codes should not be reported in this field.
- Refer to Appendix 3: National Glossary of Terms for multiple cause coding hierarchy

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Progress Notes

National Element

- National Element I_11 from the 2015 National Trauma Data Standard

National Element

ICD-10 ADDITIONAL E-CODE*

Data Format [number]

Definition

Additional external cause code used in conjuction with the primary E-Code if multiple external cause codes are required to describe the injury event.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*AdditionalECodeIcd10*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- External cause codes (E-Codes) are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)
- ICD-10-CM codes will be accepted for additional ICD-10 E-Code.
- Activity codes should not be reported in this field.
- Refer to Appendix 3: National Glossary of Terms for multiple cause coding hierarchy

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical
- Progress Notes

National Element

- National Element I_11 from the 2015 National Trauma Data Standard

National & State Element

TR41.1

REPORT OF PHYSICAL ABUSE*

Data Format [combo] single-choice

Definition

A report of suspected physical abuse was made to law enforcement and/or protective services

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AbuseReport*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Yes

2 No

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse

Data Source

- EMS Run Sheet
- ED Records
- H&P
- Nursing Notes
- Case Manager / Social Services' Notes
- Physician Discharge Summary
- History & Physical
- Progress Notes

National Element

- National Element I_20 from the 2015 National Trauma Data Standard

National & State Element

TR41.2

INVESTIGATION OF PHYSICAL ABUSE*

Data Format [combo] single-choice

Definition

An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AbuseInvestigation*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Yes 2 No

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse, or intimate partner physical abuse
- Only complete when Report of Physical Abuse is "Yes"
- The null value "Not Applicable" should be used for patient where Report of Physical Abuse is "No"

Data Source

- EMS Run Sheet
- ED Records
- Case Manager / Social Services' Notes
- H&P
- Nursing Notes
- Physician Discharge Summary
- History & Physical
- Progress Notes

National Element

- National Element I_21 from the 2015 National Trauma Data Standard

National & State Element

CAREGIVER AT DISCHARGE*

Data Format [combo] single-choice

Definition

The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*CaregiverAtDischarge*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Yes 2 No

Additional Information

- Only complete when Report of Physical Abuse is "Yes"
- Only complete for minors as determined by state/local definition, excluding emancipated minors
- The null value "Not Applicable" should be used for patient where Report of Physical Abuse is "No" or where older than the state/local age definition of a minor
- The null value "Not Applicable" should be used if the patient expires prior to discharge.

Data Source

- Case Manager / Social Services' Notes
- Physician Discharge Summary
- Nursing Notes
- Progress Notes

National Element

- National Element I_22 from the 2015 National Trauma Data Standard

National & State Element

AIRBAG PRESENT*

Data Format [combo] single-choice

Definition

Airbag in use by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

8 Yes 1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If airbag is present, complete variables: Airbag not deployed, airbag deployed side, airbag deployed front, airbag deployed other

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

AIRBAG NOT DEPLOYED*

Data Format [combo] single-choice

Definition

Indication of no airbag deployment during a motor vehicle crash.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AirbagDeployment*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Yes

- No

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

Additional Information

- Only completed when 'Airbag Present' is marked "Yes"
- Evidence of the use of airbag deployment may be reported or observed

National Element

- National Element I_19 from the 2015 National Trauma Data Standard

National Element

TR 29.19

AIRBAG DEPLOYED SIDE*

Data Format [combo] single-choice

Definition

Indication of airbag deployment on either side of the vehicle during a motor vehicle crash.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AirbagDeployment*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

3 Yes

- No

Additional Information

- Evidence of the use of airbag deployment may be reported or observed
- Only completed when 'Airbag Present' is marked "Yes"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_19 from the 2015 National Trauma Data Standard

AIRBAG DEPLOYED FRONT*

Data Format [combo] single-choice

Definition

Indication of airbag deployment in the front of the vehicle during a motor vehicle crash.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AirbagDeployment*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

2 Yes

- No

Additional Information

- "Airbag Deployed Front" should be used for patients with documented airbag deployments, but are not further specified
- Evidence of the use of airbag deployment may be reported or observed
- Only completed when 'Airbag Present' is marked "Yes"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_19 from the 2015 National Trauma Data Standard

AIRBAG DEPLOYED OTHER*

Data Format [combo] single-choice

Definition

Indication of airbag deployment of the knee, airbelt, curtain, etc. during a motor vehicle crash.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AirbagDeployment*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

4 Yes

- No

Additional Information

- Evidence of the use of airbag deployment may be reported or observed
- Only completed when 'Airbag Present' is marked "Yes"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_19 from the 2015 National Trauma Data Standard

National & State Element

TR 29.13

CHILD RESTRAINT*

Data Format [combo] single-choice

Definition

Protective child restraint devices used by patient at the time of injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

6 Yes

1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If child restraint is present, complete variables: Infant car seat, child car seat, child booster seat

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

National & State Element

INFANT CAR SEAT*

Data Format [combo] single-choice

Definition

Infant Car Seat in use by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ChildSpecificRestraint*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

2 Yes

- No

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only completed when 'Child Restraint' is marked "Yes"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_18 from the 2015 National Trauma Data Standard

CHILD CAR SEAT*

Data Format [combo] single-choice

Definition

Child Car Seat in use by the patient at the time of injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ChildSpecificRestraint*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Yes

- No

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only completed when 'Child Restraint' is marked "Yes"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_18 from the 2015 National Trauma Data Standard

CHILD BOOSTER SEAT*

Data Format [combo] single-choice

Definition

Child Booster Seat in use by the patient at the time of injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ChildSpecificRestraint*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

3 Yes

- No

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only completed when 'Child Restraint' is marked "Yes"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_18 from the 2015 National Trauma Data Standard

National & State Element

THREE POINT RESTRAINT*

Data Format [combo] single-choice

Definition

Three Point Restraint in use or worn by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

2, 10	Yes	1	No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If documentation indicates "Three Point Restraint", "Lap Belt" and "Shoulder Belt" are automatically selected, as well

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

LAP BELT*

Data Format [combo] single-choice

Definition

Lap Belt in use or worn by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

2 Yes 1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- Lap Belt should be used to include those patients that are restrained, but not further specified
- If documentation indicates "Three Point Restraint", "Lap Belt" and "Shoulder Belt" are automatically selected, as well

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

National & State Element

TR 29.14

SHOULDER BELT*

Data Format [combo] single-choice

Definition

Shoulder Belt in use or worn by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

10 Yes

1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If documentation indicates "Three Point Restraint", "Lap Belt" and "Shoulder Belt" are automatically selected, as well

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

PERSONAL FLOATATION*

Data Format [combo] single-choice

Definition

Personal Floatation Device in use or worn by the patient at the time of the injury

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

3 Yes

1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

EYE PROTECTION*

Data Format [combo] single-choice

Definition

Eye Protection in use or worn by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

5 Yes

1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

HELMET*

Data Format [combo] single-choice

Definition

Helmet (e.g., bicycle, skiing, motorcycle) in use or worn by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

7 Yes

1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

PROTECTIVE CLOTHING*

Data Format [combo] single-choice

Definition

Protective clothing (e.g., padded leather pants) in use or worn by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

9 Yes

1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

PROTECTIVE NON-CLOTHING GEAR*

Data Format [combo] single-choice

Definition

Protective non-clothing gear (e.g., shin guard) in use or worn by the patient at the time of the injury

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

4 Yes

1 No

Additional Information

- Evidence of the use of safety equipment may be reported or observed

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

OTHER*

Data Format [combo] single-choice

Definition

Other protective equipment in use or worn by the patient at the time of the injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ProtectiveDevice*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

11 Yes

- No

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- If "Yes" is selected, please describe in the box labeled "Safety Description"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element I_17 from the 2015 National Trauma Data Standard

SAFETY (Equipment) DESCRIPTION

Data Format [text]

Definition

Other protective equipment in use or worn by the patient at the time of the injury

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Evidence of the use of safety equipment may be reported or observed
- Only completed if Other is "Yes"

Data Source

- EMS Run Sheet
- Triage Form/Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

Pre-Hospital Information

ARRIVED FROM

Data Format [combo] single-choice

Definition

Location the patient arrived from

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Scene
- Clinic / MD Office
- Home
- Jail
- Nursing Home
- Referring Hospital

Data Source

- EMS Run Sheet
- 911 or Dispatch Center
- Other ED Documentation

TRANSPORTED TO YOUR FACILITY BY (EMS Transport Party)

Data Format [combo] single-choice

Definition

The mode of transport delivering the patient to your hospital

XSD Data Type	xs: integer	**XSD Element / Domain (Simple Type)**	*TransportMode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Advanced Life Support (ALS)
- Basic Life Support (BLS)
- Helicopter Ambulance
- Police
- 4 Private/Public Vehicle/Walk-In

Data Source

- EMS Run Sheet
- 911 or Dispatch Center

Additional Information

- Used to auto-generate an additional calculated field: Inter-Facility Transfer (patient transferred from another acute care facility to your facility)

National Element

- National Element P_07 from the 2015 National Trauma Data Standard

MASS CASUALTY INCIDENT

Data Format [combo] single-choice

Definition

Indicator if this event would be considered a mass casualty incident (overwhelmed existing EMS resources).

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- No
- Yes

Data Source

- EMS Run Sheet
- Trauma Flow Sheet
- 911 or Dispatch Center
- Other ED Documentation

PREGNANCY

Data Format [combo] single-choice

Definition

Indication of the possibility that the patient is currently pregnant.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- No
- Yes

Data Source

- EMS Run Sheet
- 911 or Dispatch Center
- Other ED Documentation

TR 14.39

WEIGHT (Estimated Body Weight)

Data Format [integer]

Definition

The patient's body weight in kilograms, either measured or estimated.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- If pounds are entered, converts to kilograms
- If kilograms are entered, converts to pounds

Data Source

- EMS Run Sheet
- Other ED Documentation

LAW ENFORCEMENT / CRASH REPORT NUMBER

Data Format [text]

Definition

The unique number associated with the law enforcement or crash report.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- Other ED Documentation

Uses

- Allows linkage at a later date to other State Agencies

VEHICULAR INJURY INDICATORS

Data Format [combo] single-choice

Definition

The kind of risk factor predictors associated with the vehicle involved in the incident.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Dash Deformity
- DOA Same Vehicle
- Ejection
- Fire
- Rollover / Roof Deformity
- Side Post Deformity
- Space Intrusion > 1 Foot
- Steering Wheel Deformity
- Windshield Spider / Star

Data Source

- EMS Run Sheet
- Other ED Documentation

AREA OF THE VEHICLE IMPACTED (by the Collision)

Data Format [combo] single-choice

Definition

The area or location of initial impact on the vehicle involved in the incident.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Center Front
- Center Rear
- Left Front
- Left Rear
- Left Side
- Right Front
- Right Rear
- Right Side
- Roll Over

Data Source

- EMS Run Sheet
- Other ED Documentation

SEAT ROW LOCATION (of Patient in Vehicle)

Data Format [number]

Definition

The seat row location of the patient in vehicle at the time of the crash with the front seat numbered as 1.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- Other ED Documentation

POSITION OF PATIENT (in the seat of the vehicle)

Data Format [combo] single-choice

Definition

The seat position of the patient in the vehicle at the time of the crash.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Driver
- Left (Non-driver)
- Middle
- Other
- Right

Data Source

- EMS Run Sheet
- Other ED Documentation

HEIGHT OF FALL

Data Format [number]

Definition

The distance in feet the patient fell, measured from the lowest point to the ground.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- Other ED Documentation

National & State Element

VEHICULAR, PEDESTRIAN, OTHER RISK INJURY

Data Format [combo] multi-choice

Definition

EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS run sheet.

XSD Data Type	xs: integer	**XSD Element / Domain (Simple Type)**	*VehicularPedestrianOther*
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Fall adults: > 20 ft. (one story is equal to 10 ft.)
2 Fall children: > 10 ft. or 2-3 times the height of the child
3 Crash intrusion, including roof: > 12 in. occupant site ; > 18 in. any site
4 Crash ejection (partial or complete) from vehicle
5 Crash death in same passenger compartment
6 Crash vehicle telemetry data (AACN) consistent with high risk injury
7 Auto v. pedestrian/bicyclist thrown, run over, or > 20 MPH impact
8 Motorcycle crash > 20 mph
9 For adults > 65; SBP < 110
10 Patients on the anticoagulants and bleeding disorders
11 Pregnancy > 20 weeks
12 EMS provider judgment
13 Burns
14 Burns with Trauma

Additional Information

- The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be used if the EMS Run Sheet indicates patient did not meet any Vehicular, Pedestrian, Other Risk Injury criteria
- The null value "Not Known/Not Recorded" should be used if this information is not indicated on, as an identical response choice the EMS Run Sheet or if the EMS Run Sheet is not available.
- Check all that apply

Data Source

- EMS Run Sheet

National Element

- National Element P_19 from the 2015 National Trauma Data Standard

BARRIERS TO PATIENT CARE

Data Format [combo]multiple-choice

Definition

Indication of whether or not there were any patient specific barriers to serving the patient at the scene.

Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values

Field Values

- Developmentally Impaired
- None
- Speech Impaired
- Not Available
- Hearing Impaired
- Physically Impaired
- Unattended or Unsupervised (including minors)

Data Source

- EMS Run Sheet
- Other ED Documentation

EMS RUN NUMBER

Data Format [text]

Definition

The run number assigned and entered on the run sheet of the primary emergency service, specific to the individual run/patient.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- Other ED Documentation

TR9.11

EMS Patient Care Report (PCR) Number

Data Format [text]

Definition

The run number assigned and entered on the run sheet of the primary emergency service, specific to the individual run/patient.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- Other ED Documentation

NAME OF EMS SERVICE

Data Format [combo] single-choice

Definition

The name of the EMS service that transferred the patient.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- Other ED Documentation

National & State Element

EMS DISPATCH DATE*

Data Format [date]

Definition

The date the unit *transporting to your hospital* was notified by dispatch

- For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched

XSD Data Type *xs: date*		**XSD Element / Domain (Simple Type)** *EMSNotifyDate*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

Data Source

- EMS Run Sheet
- 911 or Dispatch Center

National Element

- National Element P_01 from the 2015 National Trauma Data Standard

EMS DISPATCH TIME*

Data Format [time]

Definition

The time the unit *transporting to your hospital* was notified by dispatch

- For inter facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene was dispatched

XSD Data Type *xs: time*		**XSD Element / Domain (Simple Type)** *EMSNotifyTime*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival)

Data Source

- EMS Run Sheet
- 911 or Dispatch Center

National Element

- National Element P_02 from the 2015 National Trauma Data Standard

(EMS Unit) ARRIVAL TIME AT SCENE*

Data Format [time]

Definition

The time the unit *transporting to your hospital* arrived on the scene / transferring facility

- For inter facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined as date/time when the vehicle stopped moving)
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined as date/time when the vehicle stopped moving)

XSD Data Type *xs: time*		**XSD Element / Domain (Simple Type)** *EMSArrivalTime*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- Scene may be defined as "initial hospital" for inter-facility transfers
- HHMM should be collected as military time
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) & Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure)

Data Source

- EMS Run Sheet
- 911 or Dispatch Center

National Element

- National Element P_04 from the 2015 National Trauma Data Standard

(EMS Unit) SCENE DEPARTURE TIME*

Data Format [time]

Definition

The time the unit *transporting to your hospital* left the scene.

- For inter facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined as date/time when the vehicle started moving)
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed from the scene (departure is defined as date/time when the vehicle started moving)

XSD Data Type *xs: time*		**XSD Element / Domain (Simple Type)** *EMSLeftTime*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- Scene may be defined as "initial hospital" for inter-facility transfers
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure)

Data Source

- EMS Run Sheet
- 911 or Dispatch Center

National Element

- National Element P_06 from the 2015 National Trauma Data Standard

UNIT ARRIVED HOSPITAL TIME

Data Format [time]

Definition

The time the EMS Agency arrived with the patient at the destination of EMS transport.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HH:MM
- Scene may be defined as "initial hospital" for inter-facility transfers
- HH:MM should be collected as military time

Data Source

- EMS Run Sheet
- 911 or Dispatch Center

National & State Element

TRANSPORT MODE*

Data Format [combo] single-choice

Definition

The mode of transport delivering the patient to your hospital

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*TransportMode*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Ground Ambulance
2 Helicopter Ambulance
3 Fixed Wing Ambulance
4 Private/Public Vehicle/Walk-In
5 Police
6 Other

Additional Information

- Include in "Other" unspecified modes of transport
- The null value "Not Applicable" is used to indicate that a patient had a single mode of transport and therefor this field does not apply to the patient.
- Check all that apply with a maximum of 5

Data Source

- EMS Run Sheet
- 911 or Dispatch Center

National Element

- National Element P_07 from the 2015 National Trauma Data Standard

(Pre-Hospital Thoracentesis) / TUBE THORACOSTOMY

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of EMS

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Performed

Data Source

- EMS Run Sheet
- Other ED Documentation

TR 15.39

(Pre-Hospital) CPR PERFORMED

Data Format [combo] single-choice

Definition

Indication as to if CPR management was conducted while under the care of EMS.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Performed

Data Source

- EMS Run Sheet
- Other ED Documentation

TR 18.96

(Pre-Hospital) NEEDLE THORACOSTOMY

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of EMS.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Performed

Data Source

- EMS Run Sheet
- Other ED Documentation

TR 15.40

(Pre-Hospital) AIRWAY MANAGEMENT

Data Format [combo] single-choice

Definition

Indication as to whether a device or procedure was used to prevent or correct obstructed respiratory passage while under the care of EMS.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Bag & Mask
- Combitube
- Cricoid
- King's Airway
- LMA
- Nasal Cannula
- Non-rebreather mask
- Nasal ETT
- Oral Airway
- Oral ETT
- Trach
- Not Performed

Data Source

- EMS Run Sheet
- Other ED Documentation

(Pre-Hospital) FLUIDS

Data Format [combo] single-choice

Definition

Indication as to the amount of IV fluids that were administered to the patient while under the care of EMS.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- < 500
- 500-2000
- > 2000
- IVF Attempted
- IVF Unknown Amount

Data Source

- EMS Run Sheet
- Other ED Documentation

(Pre-Hospital) DESTINATION DETERMINATION

Data Format [combo] single-choice

Definition

Major reason for transferring the patient to the facility chosen.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Closet Facility
- Diversion
- Hospital of Choice
- On-Line Medical Direction
- Other
- Specialty Resource Center

Data Source

- EMS Run Sheet
- Other ED Documentation

TR 15.31

(Pre-Hospital) MEDICATIONS

Data Format [combo]multiple-choice

Definition

Medications given to the patient while under the care of EMS.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet
- Other ED Documentation

EMS STATUS

Data Format [combo] single-choice

Definition

Status of the EMS run sheet or Patient Care Report (PCR).

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Complete
- Incomplete
- Missing
- Pending

Data Source

- EMS Run Sheet
- Other ED Documentation

TR18.106

(Pre-Hospital) VITALS DATE

Data Format [date]

Definition

Date of first recorded vital signs in the Pre-Hospital setting.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as MM/DD/YYYY

Data Source

- EMS Run Sheet
- Other ED Documentation

(Pre-Hospital) VITALS TIME

Data Format [time]

Definition

Time of first recorded vital signs in the Pre-Hospital setting.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as HHMM
- HHMM should be collected as military time

Data Source

- EMS Run Sheet
- Other ED Documentation

National & State Element

INITIAL FIELD GCS - EYE*

Data Format [number]

Definition

First recorded Glasgow Coma Score (Eye) measured at the scene of injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*EmsGcsEye*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 4

Field Values

1 No eye movement when assessed
2 Opens eyes in response to painful stimulation
3 Opens eyes in response to verbal stimulation
4 Opens eyes spontaneously

Additional Information

- Used to calculate Overall GCS - EMS Score
- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, record as Not Known / Not Recorded
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- EMS Run Sheet

National Element

- National Element P_13 from the 2015 National Trauma Data Standard

National & State Element

TR 18.61.2 / TR 18.61.0 (ped)

INITIAL FIELD GCS - VERBAL*

Data Format [number]

Definition

First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*EmsGcsVerbal*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 5

Field Values

Pediatric (≤ 2 years):

1	No vocal response	4	Cries but is consolable, inappropriate interactions
2	Inconsolable, agitated	5	Smiles, oriented to sounds, follows objects, interacts
3	Inconsistently consolable, moaning		

Adult:

1	No vocal response	3	Inappropriate words	5	Oriented
2	Incomprehensible sounds	4	Confused		

Additional Information

- Used to calculate Overall GCS - EMS Score
- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, record as Not Known / Not Recorded
- If a patient is intubated then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- EMS Run Sheet

National Element

- National Element P_14 from the 2015 National Trauma Data Standard

National & State Element

TR 18.62.2 / TR 18.62.0 (ped)

INITIAL FIELD GCS - MOTOR*

Data Format [number]

Definition

First recorded Glasgow Coma Score (Motor) measured at the scene of injury.

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *EmsGcsMotor*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Field Values

Pediatric (≤ 2 years):

1	No motor response	4	Withdrawal from pain
2	Extension to pain	5	Localizing pain
3	Flexion to pain	6	Appropriate response to stimulation

Adult:

1	No motor response	3	Flexion to pain	5	Localizing pain
2	Extension to pain	4	Withdrawal from pain	6	Obeys commands

Additional Information

- Used to calculate Overall GCS - EMS Score
- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, record as Not Known / Not Recorded
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- EMS Run Sheet

National Element

- National Element P_15 from the 2015 National Trauma Data Standard

(Initial Field) GCS QUALIFIER (UP TO 3)

Data Format [combo]multiple-choice

Definition

Documentation of factors potentially affecting the first assessment of GCS before arrival in the ED/hospital

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*EmsGcsQualifier*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

1 Patient chemically sedated or paralyzed
2 Obstruction to the Patient's Eye
3 Patient Intubated
4 Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information

- To select more than 1, hold down the Shift Key
- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)

Data Source

- EMS Run Sheet

(Initial Field) SYSTOLIC BLOOD PRESSURE*

Data Format [number]

Definition

First recorded systolic blood pressure measured at the scene of injury.

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)**	*EmsSbp*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 400

Field Values

- Relevant value for data element

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, leave the value blank to record as "Not Known / Not Recorded"
- Used to auto-generate an additional calculated field: Revised Trauma Score - EMS (adult & pediatric)

Data Source

- EMS Run Sheet

National Element

- National Element P_09 from the 2015 National Trauma Data Standard

(Initial Field) DIASTOLIC BLOOD PRESSURE

Data Format [number]

Definition

First recorded diastolic blood pressure measured at the scene of injury.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, record as Not Known / Not Recorded

Data Source

- EMS Run Sheet

(Initial Field) PULSE RATE*

Data Format [number]

Definition

First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *EmsPulseRate*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 299

Field Values

- Relevant value for data element

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, leave blank to record as "Not Known / Not Recorded"

Data Source

- EMS Run Sheet

National Element

- National Element P_10 from the 2015 National Trauma Data Standard

(Initial Field) RESPIRATORY RATE*

Data Format [number]

Definition

First recorded respiratory rate measured at the scene of injury (expressed as a number per minute)

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *EmsRespiratoryRate*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 100

Field Values

- Relevant value for data element

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, leave blank to record as "Not Known / Not Recorded"
- Used to auto-generate an additional calculated field: Revised Trauma Score - EMS (adult & pediatric)

Data Source

- EMS Run Sheet

National Element

- National Element P_11 from the 2015 National Trauma Data Standard

(Initial Field) SP02 (Oxygen Saturation)*

Data Format [number]

Definition

First recorded oxygen saturation at the scene of injury (expressed as a percentage).

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *EmsPulseOximetry*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 100

Field Values

- Relevant value for data element

Additional Information

- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, leave blank to record as "Not Known / Not Recorded"
- Value should be based upon assessment before administration of supplemental oxygen

Data Source

- EMS Run Sheet

National Element

- National Element P_12 from the 2015 National Trauma Data Standard

INITIAL FIELD GCS - TOTAL*

Data Format [number]

Definition

First recorded Glasgow Coma Score (total) in the pre-hospital setting

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *EmsTotalGcs*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 3	**Max. Constraint:** 15

Field Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score
- Used to auto-generate an additional calculated field: Revised Trauma Score - EMS (adult & pediatric)
- If a patient does not have a numeric GCS score recorded, but there is documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", interpret this as GCS of 15, IF there is no other contradicting documentation
- If the patient is transferred to your facility with no EMS run sheet from the scene of the injury, leave blank to record as "Not Known / Not Recorded"

Data Source

- EMS Run Sheet

National Element

- National Element P_16 from the 2015 National Trauma Data Standard

(Pre-Hospital Revised Trauma Score) RTS (Total)

Data Format [number]

Definition

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the pre-hospital setting.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 4

Field Values

- Relevant value for data element

Data Source

- EMS Run Sheet

TR 18.80

(Pre-Hospital) RESPIRATORY ASSISTANCE

Data Format [combo] single-choice

Definition

The determination of mechanical and/or external support of respiration

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

1 Unassisted Respiratory Rate
2 Assisted Respiratory Rate

Data Source

- EMS Run Sheet

Referring Hospital Information

TRANSPORTED TO REFERRING FACILITY BY

Data Format [combo] single-choice

Definition

The mode of transport delivering the patient to the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- ALS Ground Ambulance
- ALS Helicopter
- BLS Ground Ambulance
- BLS Helicopter
- Other
- Police
- Private/Public Vehicle/Walk-In

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL NAME

Data Format [combo] single-choice

Definition

Name of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL ARRIVAL DATE

Data Format [date]

Definition

The date the patient arrived at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL ARRIVAL TIME

Data Format [time]

Definition

The time the patient arrived at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected in military time

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL DISCHARGE DATE

Data Format [date]

Definition

The date the patient was discharged from the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL DISCHARGE TIME

Data Format [time]

Definition

The time the patient was discharged from the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected in military time

Data Source

- Referring Hospital Medical Record Information

REFERRING HOSPITAL PHYSICIAN NAME

Data Format [text]

Definition

The name of the patient's referring physician

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Minimum Constraint: 0	**Maximum Constraint:** 50

Field Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) GCS - EYE

Data Format [number]

Definition

First recorded Glasgow Coma Score (Eye) at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 1	**Max. Constraint:** 4

Field Values

- No eye movement when assessed
- Opens eyes in response to painful stimulation
- Opens eyes in response to verbal stimulation
- Opens eyes spontaneously

Additional Information

- Used to calculate Overall GCS – Referring Hospital Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) GCS - VERBAL

Data Format [number]

Definition

First recorded Glasgow Coma Score (Verbal) at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 1	**Max. Constraint:** 5

Field Values

Pediatric (≤ 2 years):

- No vocal response
- Inconsolable, agitated
- Inconsistently consolable, moaning
- Cries but is consolable, inappropriate interactions
- Smiles, oriented to sounds, follows objects, interacts

Adult:

- No vocal response
- Incomprehensible sounds
- Inappropriate words
- Confused
- Oriented

Additional Information

- Used to calculate Overall GCS – Referring Hospital Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) GCS - MOTOR

Data Format [number]

Definition

First recorded Glasgow Coma Score (Motor) at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 1	**Max. Constraint:** 6

Adult:

- No motor response
- Extension to pain
- Flexion to pain
- Withdrawal from pain
- Localizing pain
- Obeys commands

Additional Information

- Used to calculate Overall GCS – Referring Hospital Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

TR 33.16

(Referring Hospital) GCS Assessment QUALIFIERS (UP TO 3)

Data Format [combo]multiple-choice

Definition

Documentation of factors potentially affecting the first assessment of GCS upon arrival to the referring hospital

Multiple Entry Configuration	Yes, max 3	**Accepts Null Value**	Yes, common null values

Field Values

- Patient chemically sedated
- Patient Intubated
- Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye
- Obstruction to the Patient's Eye

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- To select more than 1, hold down the Shift Key

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) TEMPERATURE

Data Format [number]

Definition

First recorded temperature (in degrees Celsius [centigrade]) at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 45°C

Field Values

- Relevant value for data element
- Used to auto-generate an additional calculated field: Temperature in degrees Fahrenheit

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) SYSTOLIC BLOOD PRESSURE

Data Format [number]

Definition

First recorded systolic blood pressure at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 299

Field Values

- Relevant value for data element

Additional Information

- Used to auto-generate an additional calculated field: Revised Trauma Score - Referring Hospital (adult & pediatric)

Data Source

- Referring Hospital Medical Record Information

TR 33.40

(Referring Hospital) DIASTOLIC BLOOD PRESSURE

Data Format [number]

Definition

First recorded diastolic blood pressure at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 299

Field Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) PULSE RATE

Data Format [number]

Definition

First recorded pulse at the referring hospital (palpated or auscultated), expressed as a number per minute

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 299

Field Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) RESPIRATORY RATE

Data Format [number]

Definition

First recorded respiratory rate at the referring hospital (expressed as a number per minute)

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 120

Field Values

- Relevant value for data element

Additional Information

- Used to auto-generate an additional calculated field: Revised Trauma Score - Referring Hospital (adult & pediatric)

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) SP02 (Oxygen Saturation)

Data Format [number]

Definition

First recorded oxygen saturation at the referring hospital (expressed as a percentage)

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 100

Field Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) MANUAL GCS TOTAL

Data Format [number]

Definition

First recorded Glasgow Coma Score (total) at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 3	**Max. Constraint:** 15

Field Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score
- Used to auto-generate an additional calculated field: Revised Trauma Score - Referring Hospital (adult & pediatric)
- If a patient does not have a numeric GCS score recorded, but with documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", interpret this as GCS of 15, IF there is no other contradicting documentation
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital Revised Trauma Score) RTS (Total)

Data Format [number]

Definition

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient at the referring hospital setting.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 4

Field Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score
- Auto-generated if Manual GCS - Total is entered

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital Pediatric Trauma Score) PTS (Total)

Data Format [number]

Definition

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient at the referring hospital setting for a pediatric patient.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: -6	**Max. Constraint:** 12

Field Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score

Data Source

- Referring Hospital Medical Record Information

(Referring) HOSPITAL ICU

Data Format [combo] single-choice

Definition

Determination of whether or not the patient went to the ICU at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Yes
- No

Data Source

- Referring Hospital Medical Record Information
- Other ICU Documentation

(Referring) HOSPITAL OR

Data Format [combo] single-choice

Definition

Determination of whether or not the patient went to the OR at the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Yes
- No

Data Source

- Referring Hospital Medical Record Information
- Other OR Documentation

(Referring) CPR PERFORMED

Data Format [combo] single-choice

Definition

Indication as to if CPR management was conducted while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Yes
- No

Data Source

- Referring Hospital Medical Record Information

TR 33.21

(Referring Hospital) CT HEAD (Results)

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

TR 33.33

(Referring Hospital) CT CERVICAL (Results)

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) CT ABD/PELVIS (Results)

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) CT CHEST (Results)

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

TR 33.24

(Referring Hospital) ABDOMINAL ULTRASOUND (Results)

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

TR 33.25

(Referring Hospital) AORTOGRAM (Results)

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Positive
- Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

TR 33.26

(Referring Hospital) ARTERIOGRAM (Results)

Data Format [combo] single-choice

Definition

Indication as to if this procedure was performed while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Positive
- Negative

Data Source

- Referring Hospital Medical Record Information
- Radiology Report

(Referring Hospital) AIRWAY MANAGEMENT

Data Format [combo] single-choice

Definition

Indication as to whether a device or procedure was used to prevent or correct an obstructed airway passage while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Bag & Mask
- Combitube
- Cricoid
- LMA
- Nasal ETT
- Oral Airway
- Oral ETT
- Trach

Data Source

- Referring Hospital Medical Record Information
- Other ED Documentation

(Referring Hospital) DESTINATION DETERMINATION

Data Format [combo] single-choice

Definition

The reason the facility transferred this patient to another acute care hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Hospital of Choice
- Specialty Resource Center

Data Source

- Referring Hospital Medical Record Information

(Referring Hospital) MEDICATIONS

Data Format [combo]multiple-choice

Definition

Indication as to which, if any, medications were administered to the patient while under the care of the referring hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Referring Hospital Medical Record Information

ED / Acute Care Information

DIRECT ADMIT TO HOSPITAL

Data Format [combo] single-choice

Definition

Indicates if the patient was a direct admission

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- No
- Yes

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Registration
- Hospital Discharge Summary

DATE ARRIVED IN ED/ACUTE CARE*

Data Format [date]

Definition

The date the patient arrived to the ED / Hospital

XSD Data Type *xs: date*		**XSD Element / Domain (Simple Type)** *HospitalArrivalDate*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Field Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter date patient arrived at ED. If patient was directly admitted to the hospital, enter date patient was admitted to the hospital
- Collected as MM/DD/YYYY
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED / Hospital Arrival to ED / Hospital Discharge)

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary
- Face Sheet

National Element

- National Element ED_01 from the 2015 National Trauma Data Standard

TIME ARRIVED IN ED/ACUTE CARE*

Data Format [time]

Definition

The time the patient arrived at the ED / Hospital

XSD Data Type	*xs: time*	**XSD Element / Domain (Simple Type)**	*HospitalArrivalTime*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- If the patient was brought to the ED, enter time patient arrived at ED. If patient was directly admitted to the hospital, enter time patient was admitted to the hospital
- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED / Hospital Arrival to ED / Hospital Discharge)

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary
- Face Sheet

National Element

- National Element ED_02 from the 2015 National Trauma Data Standard

TRAUMA TEAM ACTIVATED

Data Format [radio]

Definition

Level of Trauma Team activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Activated
- Level 1
- Level 2
- Level 3
- Level 4

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

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DATE TRAUMA TEAM ACTIVATED

Data Format [date]

Definition

The date the trauma team was activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

TIME TRAUMA TEAM ACTIVATED

Data Format [time]

Definition

The time the trauma team was activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

TEAM MEMBER

Data Format [combo] single-choice

Definition

Name of the team member called when trauma team was activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

(Trauma Team Member) SERVICE TYPE

Data Format [combo] single-choice

Definition

The specialty of the team member (physician) called for the Trauma Team Activation

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Anesthesia
- Emergency Medicine
- Family Practice
- Neurosurgery
- Nurse Practitioner
- Orthopedic Surgery
- Physician Assistant
- Surgery Senior Resident
- Surgery / Trauma

Additional Information

- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

DATE (Trauma Team Member) CALLED

Data Format [date]

Definition

The date the team member (physician) was called when the trauma team was activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

TIME (Trauma Team Member) CALLED

Data Format [time]

Definition

The time the team member (physician) was called when the trauma team was activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

DATE (Trauma Team Member) ARRIVED

Data Format [date]

Definition

The date the team member (physician) arrived when the trauma team was activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

TIME (Trauma Team Member) ARRIVED

Data Format [time]

Definition

The time the team member (physician) arrived when the trauma team was activated

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Trauma Team is activated

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Trauma Team) TIMELY ARRIVAL

Data Format [combo] single-choice

Definition

Did the team member (ED physician) respond to the call to see the patient in a timely manner?

Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values

Field Values

- Yes
- No

Additional Information

- Only completed if Trauma Team is activated
- Criteria for timely arrival is defined by the facility

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

ADMITTING MD/STAFF

Data Format [combo] single-choice

Definition

Physician or staff member's name to which the patient is designated upon admission to the facility

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

ADMITTING SERVICE

Data Format [combo] single-choice

Definition

The department within the hospital that admitted the patient after being discharged from the ED

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Cardiology
- Cardiovascular Surgery
- Ears, Nose, Throat (ENT)
- Family Practice
- Gastrointestinal (GI)
- Hospitalist
- Infection Control
- Internal Medicine
- Ophthalmology
- Medicine
- Nephrology
- Neurology
- Neurosurgery
- Orthopedics
- Pediatric Surgery
- Plastic Surgery
- Surgery Subspecialty
- Trauma

Additional Information

- Burn, OMFS, Hand, etc. fall under "Surgery Subspecialty"

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

CONSULTING SERVICES

Data Format [combo] single-choice

Definition

The determination that consulting services were provided

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Yes
- No

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

(Consulting) SERVICE TYPE

Data Format [combo] single-choice

Definition

The specialty of any consults made during the patient's time at the hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Acute Rehabilitation Medicine
- Anesthesia
- Bariatric
- Burn
- Cardiology
- Cardiothoracic Surgery
- Chemical Dependence
- Critical Care Medicine
- Critical Care Surgery
- Dentistry
- Dermatology
- Endocrinology
- Ear Nose Throat
- Family Medicine
- Gastroenterology
- General Surgery
- Geriatric
- Gynecology
- Hand
- Hematology Oncology
- Infectious Disease
- Internal Medicine
- Kidney Transplant
- Liver
- Neonatal
- Nephrology
- Neurology
- Neurosurgery
- Obstetric
- Occuloplastic
- Ophthalmology
- Oral Maxillo Facial Surgery
- Orthopedic Surgeon
- Other Non-Surgical Service
- Other Surgical Service
- Pain
- Pediatric Cardiology
- Pediatric Critical Care Medicine
- Pediatric Dentistry
- Pediatric Gastroenterology
- Pediatric Hematology Oncology
- Pediatric Infectious Disease
- Pediatric Nephrology
- Pediatric Neurology
- Pediatric Orthopedic
- Pediatric Pulmonary
- Plastic Surgeon
- Psychiatry
- Psychology
- Trauma Surgeon
- Rheumatology
- Urology
- Vascular Surgery

Additional Information

- Only completed if Consulting Services is "Yes"

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

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CONSULTING STAFF

Data Format [combo] single-choice

Definition

Name of staff member that consulted on the patient

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Consulting Services is "Yes"

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
  Hospital Discharge Summary

DATE (Consulting Practitioner Requested)

Data Format [date]

Definition

The date the consultant was called

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Only completed if Consulting Services is "Yes"

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

TIME (Consulting Practitioner Requested)

Data Format [time]

Definition

The time the consultant was called

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if Consulting Services is "Yes"

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Hospital Registration
- Hospital Discharge Summary

National & State Element

DATE DISCHARGED FROM ED*

Data Format [date]

Definition

The date the patient was discharged from the ED

XSD Data Type	*xs: date*	**XSD Element / Domain (Simple Type)**			
	EdDischargeDate	**Multiple Entry Configuration**	No	**Accepts Null Value**	
	Yes, common null values	**Required in XSD**		Yes	**Min.**

Constraint: 1990 **Max. Constraint:** 2030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated field: Total ED Time: (elapsed time from ED admit to ED discharge)
- Leave the value blank to use the null value "Not Applicable" if the patient is directly admitted to the hospital.

Data Source

- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet
- Physician's Progress Notes
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National Element

- National Element ED_21 from the 2015 National Trauma Data Standard

(ED) DISCHARGE TIME*

Data Format [time]

Definition

The time the patient was discharged from the ED

XSD Data Type	*xs: time*	**XSD Element / Domain (Simple Type)**	*EDDischargeTime*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total ED Time: (elapsed time from ED admit to ED discharge)
- Leave the value blank to use the null value "Not Applicable" if the patient is directly admitted to the hospital.

Data Source

- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet
- Physician's Progress Notes
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation

National Element

- National Element ED_22 from the 2015 National Trauma Data Standard

ED (Discharge) DISPOSITION*

Data Format [combo] single-choice

Definition

The disposition of the patient at the time of discharge from the ED

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*EdDischargeDisposition*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Floor bed (general admission, non-specialty unit bed)
2 Observation Unit (unit that provides < 24 hour stays)
3 Telemetry / step-down unit (less acuity than ICU)
4 Home with Services
5 Deceased / Expired
6 Other (jail, institutional care, mental health, etc.)
7 Operating Room
8 Intensive Care Unit (ICU)
9 Home without services
10 AMA (Left against medical advice)
11 Transferred to another hospital

Additional Information

- Based upon UB-04 disposition coding.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- **If a patient originated from an institutional care facility, jail, or skilled nursing facility and then was discharged from the ED to the same institutional care facility, jail, or skilled nursing facility, you would use the field value 4. Home with Services or 9. Home without Services.**

- If a patient originated from home and then was discharged from the ED to an institutional care facility, jail, or skilled nursing facility, you would use the field value 6. Other (jail, institutional care, mental health, etc.)
- If ED Discharge Disposition is "Home with services", "Died / Expired", "Other (jail, institutional care, mental health, etc.)", "Home without services", "Left against medical advice", or "Transferred to another hospital", then Hospital Discharge Date, Time, and Disposition should be "Not Applicable"

Data Source

- Hospital Discharge Documentation
- Nursing Progress Notes
- Social Worker Notes
- Other Hospital Documentation

National Element

- National Element ED_19 from the 2015 National Trauma Data Standard

National & State Element

Signs of Life*

Data Format [combo] single-choice

Definition

Indication of whether patient arrived at ED/Hospital with signs of life

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*DeathInEd**
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Arrived with NO signs of life
2 Arrived with signs of life

Additional Information

- A patient with no signs of life is defined as having none of the following: organized EKG activity, papillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.
- Only completed if ED Disposition is "Died"

Data Source

- Triage Form / Trauma Flow Sheet
- ED Physician's Notes
- ED Nurses' Notes
- Other ED Documentation
- History & Physical

National Element

- National Element ED_20 from the 2015 National Trauma Data Standard

**Please note that the XSD element is still referred to as DeathInED, however the field name and definition have changed to Signs of Life*

(Operating Room) OR DISCHARGE DISPOSITION

Data Format [combo] single-choice

Definition

The disposition of the patient following post-anesthesia recovery

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Died
- Floor bed (general admission, non-specialty unit bed)
- Home with Services
- Home without Services
- Intensive Care Unit (ICU)
- Left against medical advice (AMA)
- Observation unit (unit that provides < 24 hour stays)
- Other (jail, hospice, institution, etc.)
- Post-Anesthesia Care Unit (PACU)
- Telemetry / step-down unit (less acuity than ICU)
- Transferred to another hospital

Additional Information

- Only completed if ED Disposition is "Operating Room"
- SICU, CCU, MICU fall under the ICU category

Data Source

- OR Nurses' Notes
- Operative Records

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DATE OF DECISION TO TRANSFER

Data Format [date]

Definition

The date it was decided that the patient would be transferred

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source

- Triage Form / Trauma Flow Sheet
- ED Physician's Notes
- ED Nurses' Notes
- Other ED Documentation

TIME OF DECISION TO TRANSFER

Data Format [time]

Definition

The time it was decided that the patient would be transferred

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

TRANSFER DELAY

Data Format [combo] single-choice

Definition

Indication of a delay in transferring the patient to a hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Yes
- No

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

REASON FOR TRANSFER DELAY

Data Format [combo] single-choice

Definition

Reason for delay in transferring the patient

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- EMS issue
- Other
- Receiving hospital issue
- Referring Physician Decision Making
- Referring Hospital Issue - Radiology
- Weather or Natural Factors

Additional Information

- Only completed if ED Disposition is "Transferred to another Hospital"

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

OTHER REASON FOR TRANSFER DELAY

Data Format [text]

Definition

Other reason for transfer delay that is not specific in the reason for transfer delay drop down menu

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Reason for Transfer Delay is "Other"

Data Source

- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Hospital Discharge Summary
- Billing Sheet / Medical Records Summary Sheet

Initial Assessment Information

(Initial ED/Hospital) VITALS DATE

Data Format [date]

Definition

The date of the first recorded vitals in the ED/Hospital setting

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

(Initial ED/Hospital) VITALS TIME

Data Format [time]

Definition

The time of the first recorded vitals in the ED/Hospital setting

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected in military time

Data Source

- Triage Form/Trauma Flow Sheet
- Billing Sheet / Medical Records Coding Summary Sheet
- ED Nurses' Notes
- Other ED Documentation

National & State Element

TR 18.14

(Initial ED/Hospital) GCS - EYE*

Data Format [number]

Definition

First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/Hospital arrival time

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*GcsEye*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 4

Field Values

1 No eye movement when assessed
2 Opens eyes in response to painful stimulation
3 Opens eyes in response to verbal stimulation
4 Opens eyes spontaneously

Additional Information

- Used to calculate Overall GCS - ED Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED documentation
- Nurses notes
- Physician Notes/Flow Sheet

National Element

- National Element ED_10 from the 2015 National Trauma Data Standard

(Initial ED / Hospital) GCS - VERBAL*

Data Format [number]

Definition

First recorded Glasgow Coma Score (Verbal) in the ED/hospital within 30 minutes or less of ED/hospital arrival time

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*GcsVerbal*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 5

Field Values

Pediatric (≤ 2 years):

1	No vocal response	4	Cries but is consolable, inappropriate interactions		
2	Inconsolable, agitated	5	Smiles, oriented to sounds, follows objects, interacts		
3	Inconsistently consolable, moaning				

Adult:

1	No verbal response	3	Inappropriate words	5	Oriented
2	Incomprehensible sounds	4	Confused		

Additional Information

- Used to calculate Overall GCS - ED Score
- If patient is intubated then the GCS Verbal score is equal to 1
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes
- Physician Notes/Flow Sheet

National Element

- National Element ED_11 from the 2015 National Trauma Data Standard

National & State Element

TR 18.16.2 / TR 18.16.0 (ped)

(Initial ED/Hospital) GCS - MOTOR*

Data Format [number]

Definition

First recorded Glasgow Coma Score (Motor) in the ED/hospital within 30 minutes or less of ED/hospital arrival

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)**	*GcsMotor*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Field Values

Pediatric (≤ 2 years):

1	No motor response	4	Withdrawal from pain
2	Extension to pain	5	Localizing pain
3	Flexion to pain	6	Appropriate response to stimulation

Adult:

1	No motor response	3	Flexion to pain	5	Localizing pain
2	Extension to pain	4	Withdrawal from pain	6	Obeys commands

Additional Information

- Used to calculate Overall GCS - ED Score
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of function within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus", a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes
- Physician Notes/Flow Sheet

National Element

- National Element ED_12 from the 2015 National Trauma Data Standard

National & State Element

(Initial ED/Hospital) GCS Assessment QUALIFIERS (UP TO 3)*

Data Format [combo] multiple-choice

Definition

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*GcsQualifier*
Multiple Entry Configuration	Yes, max 3	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Patient chemically sedated or paralyzed
2 Obstruction to the Patient's Eye
3 Patient Intubated
4 Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye

Additional Information

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.)
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes
- Please note that the first recorded hospital vitals do not need to be from the same assessment
- To select more than 1, hold down the Shift Key

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- EMS Run Sheet
- Nurses notes
- Physician Notes/ Flow Sheet

National Element

- National Element ED_14 from the 2015 National Trauma Data Standard

National & State Element

(Initial ED/Hospital) TEMPERATURE*

Data Format [number]

Definition

First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *Temperature*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 45.0°C

Field Values

- Relevant value for data element

Additional Information

- Please note that the first recorded hospital vitals do not need to be from the same assessment
- Used to auto-generate an additional calculated field: Temperature in degrees Fahrenheit

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes

National Element

- National Element ED_05 from the 2015 National Trauma Data Standard

National & State Element

(Initial ED/Hospital) SYSTOLIC BLOOD PRESSURE*

Data Format [number]

Definition

First recorded systolic blood pressure in the ED/hospital, within 30 minutes or less of ED/hospital arrival

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Sbp*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 299

Field Values

- Relevant value for data element

Additional Information

- Used to auto-generate an additional calculated field: Revised Trauma Score - ED (adult & pediatric)
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes
- Physician Notes
- History & Physical

National Element

- National Element ED_03 from the 2015 National Trauma Data Standard

(Initial ED/Hospital) DIASTOLIC BLOOD PRESSURE

Data Format [number]

Definition

First recorded diastolic blood pressure within 30 minutes or less of ED/hospital arrival

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 299

Field Values

- Relevant value for data element

Additional Information

- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes

National & State Element

(Initial ED/Hospital) PULSE RATE*

Data Format [number]

Definition

First recorded pulse (palpated or auscultated) in the ED/hospital, within 30 minutes or less of ED/hospital arrival time (expressed as a number per minute)

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)**	*PulseRate*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 300

Field Values

- Relevant value for data element

Additional Information

- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes

National Element

- National Element ED_04 from the 2015 National Trauma Data Standard

National & State Element

TR 18.7

(Initial ED/Hospital) RESPIRATORY RATE*

Data Format [number]

Definition

First recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute)

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *RespiratoryRate*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 120

Field Values

- Relevant value for data element

Additional Information

- If available, complete additional field: "Initial ED/Hospital Respiratory Assistance"
- Used to auto-generate an additional calculated field: Revised Trauma Score - ED (adult & pediatric)
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes
- Respiratory Therapy Notes/Flow Sheet

National Element

- National Element ED_06 from the 2015 National Trauma Data Standard

National & State Element

(Initial ED/Hospital) SP02 (Oxygen Saturation)*

Data Format [number]

Definition

First recorded oxygen saturation in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage)

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*PulseOximetry*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 0	**Max. Constraint:** 100

Field Values

- Relevant value for data element

Additional Information

- If available, complete additional field: "Initial ED/Hospital Supplemental Oxygen"
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes
- Respiratory Therapy Notes/Flow Sheet

National Element

- National Element ED_08 from the 2015 National Trauma Data Standard

National & State Element

(Initial ED/Hospital) MANUAL GCS TOTAL*

Data Format [number]

Definition

First recorded Glasgow Coma Score (total) in the ED/hospital within 30 minutes or less of ED/hospital arrival

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*TotalGcs*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 15

Field Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score
- Used to auto-generate an additional calculated field: Revised Trauma Score - ED (adult & pediatric)
- If a patient does not have a numeric GCS score recorded, but with documentation related to their level of consciousness such as "AAOx3", "awake alert and oriented", or "patient with normal mental status", interpret this as GCS of 15, IF there is no other contradicting documentation
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Nurses notes
- Physician Notes / Flow Sheet

National Element

- National Element ED_13 from the 2015 National Trauma Data Standard

(Initial ED/hospital Revised Trauma Score) RTS (Total)

Data Format [number]

Definition

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 4

Field Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score
- Auto-generated if Manual GCS - Total is entered

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/hospital Pediatric Trauma Score) PTS (Total)

Data Format [number]

Definition

A physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting for a pediatric patient.

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: -6	**Max. Constraint:** 12

Field Values

- Relevant value for data element

Additional Information

- Use only if total score is available without component score

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) SUPPLEMENTAL OXYGEN*

Data Format [combo] single-choice

Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*SupplementalOxygen*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 No (No Supplemental Oxygen)
2 Yes (Supplemental Oxygen)

Additional Information

- Only completed if a value is provided for "Initital ED/Hospital Oxygen Saturation"
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED documentation
- Nurses notes / Flow Sheet

National Element

- National Element ED_09 from the 2015 National Trauma Data Standard

National & State Element

TR 18.10

(Initial ED/Hospital) RESPIRATORY ASSISTANCE*

Data Format [combo] single-choice

Definition

Determination of respiratory assistance associated with the Initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*RespiratoryAssistance*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 No (Unassisted Respiratory Rate)
2 Yes (Assisted Respiratory Rate)

Additional Information

- Only completed if a value is provided for "Initial ED/Hospital Respiratory Rate"
- Respiratory assistance is defined as mechanical and/or external support of respiration
- Please note that the first recorded hospital vitals do not need to be from the same assessment

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED documentation
- Nurses notes
- Respiratory Therapy Notes / Flow Sheet

National Element

- National Element ED_07 from the 2015 National Trauma Data Standard

(Initial ED/Hospital) AIRWAY MANAGEMENT

Data Format [combo] single-choice

Definition

Indication as to whether a device or procedure was performed to prevent or correct an obstructed respiratory passage while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Bag & Mask
- Combitube
- Cricoid
- LMA
- Nasal Cannula
- Non-rebreather mask
- Nasal ETT
- Oral Airway
- Oral ETT
- Trach
- Not Performed

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

TR 18.71

(Initial ED / Hospital) CPR PERFORMED

Data Format [combo] single-choice

Definition

Indication as to if CPR management was conducted while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Performed

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

UNITS OF BLOOD

Data Format [number]

Definition

Number of units of blood (PRBC, FFP, Plts) administered to the patient in the first 24 hours

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

BLOOD ORDERED DATE

Data Format [date]

Definition

Date and time the blood was ordered for the patient in the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

CROSSMATCH DATE

Data Format [date]

Definition

Date and time the blood was crossmatched for the patient in the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

BLOOD ADMINISTERED DATE

Data Format [date]

Definition

Date and time the blood was administered to the patient in the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) CT HEAD (Results)

Data Format [combo] single-choice

Definition

Indication as to if the procedure was performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

TR 18.73

(Initial ED/Hospital) CT ABD/PELVIS (Results)

Data Format [combo] single-choice

Definition

Indication as to if the procedure was performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) CT CHEST (Results)

Data Format [combo] single-choice

Definition

Indication as to if the procedure was performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) CT CERVICAL (Results)

Data Format [combo] single-choice

Definition

Indication as to if the procedure was performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

TR 18.101

(Initial ED/Hospital) DATE SENT TO CT

Data Format [date]

Definition

The date the patient had a CT performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) TIME SENT TO CT

Data Format [time]

Definition

The time the patient had a CT performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected in military time

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

(Initial ED/Hospital) ABDOMINAL ULTRASOUND DATE

Data Format [date]

Definition

The date the abdominal ultrasound was performed on the patient while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as MM/DD/YYYY

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

TR 18.112

(Initial ED/Hospital) ABDOMINAL ULTRASOUND TIME

Data Format [time]

Definition

The time the abdominal ultrasound was performed on the patient while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Collected as HHMM
- HHMM should be collected in military time

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation

TR 18.75

(Initial ED/Hospital) ABDOMINAL ULTRASOUND (Results)

Data Format [combo] single-choice

Definition

Indication as to if the procedure was performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Not Performed
- Positive
- Negative

Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) ARTERIOGRAM (Results)

Data Format [combo] single-choice

Definition

Indication as to if the procedure was performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Positive
- Negative

Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

(Initial ED/Hospital) AORTOGRAM (Results)

Data Format [combo] single-choice

Definition

Indication as to if the procedure was performed while under the care of the ED/Hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Positive
- Negative

Additional Information

- "Positive" is defined as 'any traumatic injury'
- "Negative" is defined as 'no traumatic injury'

Data Source

- Triage Form / Trauma Flow Sheet
- Other ED Documentation
- Radiology Report

National & State Element

ALCOHOL USE INDICATOR*

Data Format [combo] single-choice

Definition

Use of alcohol by the patient

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AlcoholUseIndicators*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 No (Not Tested)
2 No (confirmed by test)
3 Yes (confirmed by test [trace levels])
4 Yes (confirmed by test [beyond legal limit])

Additional Information

- Blood alcohol concentration (BAC) may be documented at any facility (or setting) treating this patient event
- If alcohol use is "Yes", complete variable: Blood Alcohol Content (BAC)
- "Trace levels" is defined as any alcohol level below the legal limit, but not zero
- "Beyond legal limit" is defined as a blood alcohol concentration above the legal limit for the state in which the treating institution is located. Above any legal limit, DUI, DWI, or DWAI, would apply here
- If alcohol use is suspected, but not confirmed by test, record null value "Not Known/Not Recorded"

Data Source

- Lab results (facility specific ; inter-facility data not valid)
- ED Physicians Notes
- Nursing Notes / Flow Sheet
- History & Physical

National Element

- National Element ED_17 from the 2015 National Trauma Data Standard

BLOOD ALCOHOL CONTENT (BAC)

Data Format [number]

Definition

Indicates the measure of ethyl alcohol in a blood sample obtained from the patient for laboratory examination (reported in mg/dl)

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Blood alcohol concentration (BAC) may be documented at any facility (or setting) treating this patient event
- Only completed when "Alcohol Use Indicator" is selected as "Yes"

Data Source

- Lab results (facility specific ; inter-facility data not valid)

(Initial ED / Hospital) BASE DEFICIT

Data Format [number]

Definition

The first recorded base deficit (the arterial blood gas component showing the degree of acid/base imbalance), measured in mEq/L

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Lab results (facility specific ; inter-facility data not valid)

National & State Element

DRUG USE INDICATOR*

Data Format [combo] multiple-choice

Definition

Use of drugs by the patient

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*DrugUseIndicator*
Multiple Entry Configuration	Yes, max 2	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1	No (not tested)
2	No (confirmed by test)
3	Yes (confirmed by test [rX drug])
4	Yes (confirmed by test [illegal use drug])
3, 4	Yes (confirmed by test [rX & illegal use drug])

Additional Information

- Drug use may be documented at any facility (setting) treating this patient event
- If positive, indicate classification or drug specific information
- "Illegal use drug" includes illegal use of prescription drugs
- If drug use is suspected, but not confirmed by test, record null value "Not Known / Not Recorded"
- This data element refers to drug use by the patient and does not include medical treatment
- Check all that apply

Data Source

- Lab results (facility specific ; inter-facility data not valid)
- ED Physician Documentation
- Nursing Notes / Flow Sheet
- History & Physical

National Element

- National Element ED_18 from the 2015 National Trauma Data Standard

DRUG (Involvement Toxic) SCREEN

Data Format [combo] multiple-choice

Definition

Laboratory test used to detect the presence of drugs in the patient's blood. Enter the drugs present when drug screening was performed in ED. You may enter more than one drug. Do not include drugs given to the patient during any phase of resuscitation

Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values

Field Values

- Amphetamine
- Antidepressants (including Tricyclics)
- Barbiturate
- Benzodiazepines (Valium)
- Cocaine
- Ethanol
- Marijuana (cannabis)
- Methamphetamines
- Opiates (including Propoxyphene)
- PCP

Additional Information

- Drug use may be documented at any facility (setting) treating this patient event
- Only completed when "Drug Use Indicator" is selected as "Yes"

Data Source

- Lab results (facility specific ; inter-facility data not valid)
- ED Physician Documentation

DiagnosisInformation

National & State Element

ICD-9 CODE (Injury Diagnosis)*

Data Format [combo]multiple-choice

Definition

Diagnoses related to all identified injuries.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*InjuryDiagnosis*
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Injury diagnoses as defined by ICD-9-CM range: 800-959.9m except for 905-909.9, 910-924.9, 930-939.9
- The maximum number of diagnoses that may be reported for an individual patient is 50

Additional Information

- ICD-9-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this field
- Used to auto-generate eight additional calculated fields: Abbreviated Injury Scale (six body regions), Injury Severity Score, and the Functional Capacity Index
- The null value "Not Applicable" is used if not coding ICD-9.

Data Source

- Hospital Discharge Summary
- Billing Sheet / Medical Records Coding Summary Sheet
- Trauma Flow Sheet
- ER and ICU Records
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation
- Autopsy/Medical Examiner Report
- Operative Reports
- Radiology Reports

National Element

- National Element DG_2 from the 2015 National Trauma Data Standard

National & State Element

ICD-10 CODE (Injury Diagnosis)*

Data Format [combo]multiple-choice

Definition

Diagnoses related to all identified injuries

XSD Data Type	*xs: string*		**XSD Element / Domain (Simple Type)**	*Diagnosis Icd10*
Multiple Entry Configuration	Yes, max 100		**Accepts Null Value**	Yes, common null values
Required in XSD	Yes			

Field Values

- Injury diagnoses as defined by ICD-10-CM code range: S00-S99, T07, T14, T20-T28, T30-T32, and T79.A1-T79.A9 code range.
- The maximum number of diagnoses that may be reported for an individual patient is 100

Additional Information

- ICD-10-CM codes pertaining to other medical conditions (e.g., CVA, MI, co-morbidities, etc.) may also be included in this field
- Used to auto-generate eight additional calculated fields: Abbreviated Injury Scale (six body regions), Injury Severity Score, and the Functional Capacity Index
- The null value "Not Applicable" is used if not coding ICD-10.

Data Source

- Hospital Discharge Summary
- Billing Sheet / Medical Records Coding Summary Sheet
- Trauma Flow Sheet
- ER and ICU Records
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation
- Autopsy/Medical Examiner Report
- Operative Reports
- Radiology Reports

National Element

- National Element DG_3 from the 2015 National Trauma Data Standard

AIS 05 (Predot) CODE*

Data Format [combo]multiple-choice

Definition

The Abbreviated Injury Scale (AIS) predot codes that reflect the patient's injuries

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AisPredot*
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- The predot code is the 6 digits preceding the decimal point in an associated AIS code

Additional Information

- This variable is considered *optional* and is not required as part of the State dataset

Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

National Element

- National Element IS_01 from the 2015 National Trauma Data Standard

AIS VERSION*

Data Format [text]

Definition

The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity codes

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*AisVersion*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 AIS 80
2 AIS 85
3 AIS 90
4 AIS 95
5 AIS 98
6 AIS 05

Additional Information

- This variable is considered *optional* and is not required as part of the State dataset

National Element

- National Element IS_04 from the 2015 National Trauma Data Standard

Optional National & State Element

ISS (Body) REGION*

Data Format [number]

Definition

The Injury Severity Score (ISS) body region codes that reflects the patient's injuries

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*IssRegion*
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 6

Field Values

1 Head or Neck
2 Face
3 Chest
4 Abdominal or pelvic contents
5 Extermities or pelvic girdle
6 External

Additional Information

- Auto-calculated once AIS code is typed in
- This variable is considered *optional* and is not required as part of the State dataset
- Head or neck injuries include injury to the brain or cervical spine, skull or cervical spine fractures
- Facial injuries include those involving mouth, ears, nose and facial bones
- Chest injuries include all lesions to internal organs. Chest injuries also include those to the diaphragm, rib cage, and thoracic spine
- Abdominal or pelvic contents injuries include all lesions to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region
- Injuries to the extremities or to the pelvic or shoulder girdle include sprains, fractures, dislocations, and amputations, except for the spinal column, skull and rib cage
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface

Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

National Element

- National Element IS_03 from the 2015 National Trauma Data Standard

Optional National & State Element

AIS BASED INJURY SEVERITY SCORES BY DIAGNOSIS*

Data Format [number]

Definition

The Abbreviated Injury Scale (AIS) severity codes that reflect the patient's injuries

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)**	*AisSeverity*
Multiple Entry Configuration	Yes, max 50	**Accepts Null Value**	Yes, common null values
Required in XSD Yes		**Min. Constraint:** 1	**Max. Constraint:** 9

Field Values

1 Minor Injury
2 Moderate Injury
3 Serious Injury
4 Severe Injury
5 Critical Injury
6 Maximum Injury, Virtually Insurvivable
9 Not Possible to Assign

Additional Information

- This variable is considered *optional* and is not required as part of the State dataset
- The field value (9) "Not Possible to Assign" would be chosen if it is not possible to assign a severity to an injury

Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

National Element

- National Element IS_02 from the 2015 National Trauma Data Standard

Optional National & State Element

MANUAL (Locally Calculated ISS)*

Data Format [number]

Definition

The Injury Severity Score (ISS) that reflects the patient's injuries

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)**	*IssLocal*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 75

Field Values

- Auto-calculated once AIS scores are typed in
- Relevant ISS value for the constellation of injuries

Additional Information

- This variable is considered *optional* and is not required as part of the State dataset

Data Source

- Hospital Discharge Summary
- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

National Element

- National Element IS_05 from the 2015 National Trauma Data Standard

Comorbidity Information

CO-MORBID CONDITIONS*

Data Format [combo]multiple-choice

Definition

Pre-existing co-morbid factors present before patient arrival at the ED/Hospital

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*ComorbidCondition*
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1	Other
2	Alcoholism
3	~~RETIRED 2015 Ascites within 30 days~~
4	Bleeding disorder
5	Currently receiving chemotherapy for cancer
6	Congenital Anomalies
7	Congestive Heart Failure
8	Current smoker
9	Chronic renal failure
10	CVA/residual neurological deficit
11	Diabetes mellitus
12	Disseminated cancer
13	Advanced directive limiting care
~~14~~	~~RETIRED 2015 Esophageal varices~~
15	Functionally dependent health status
16	History of angina within 30 days
17	Hist. of myocardial infarction
18	History of PVD
19	Hypertension requiring medication
21	Prematurity
~~22~~	~~RETIRED 2015 Obesity~~
23	Respiratory Disease
24	Steroid Use
25	Cirrhosis
26	Dementia
27	Major psychiatric illness
28	Drug use disorder
29	~~RETIRED 2015 Pre-hospital cardiac arrest with resuscitative efforts by healthcare provider~~
30	Attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD)

Additional Information

- The null value "Not Applicable" is used for patients with no known co-morbid conditions
- Refer to Appendix 3: National Glossary of Terms for definition of Co-Morbid Conditions
- Select all that apply

Data Source

- History and Physical
- Discharge Sheet
- Billing Sheet
- Case Management/Social Services
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation
- Triage/Trauma Flow Sheet

National Element

National Element DG_01 from the 2015 National Trauma Data Standard

CO-MORBID CONDITION NOTES

Data Format [text]

Definition

Additional information about the pre-existing medical conditions

Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
		Min Constraint: 0	**Max Constraint:** 2000

Field Values

- Relevant value for data element

Data Source

- History and Physical
- Physician's Documentation
- Nurses' Notes
- Other Hospital Documentation

ProceduresInformation

PROCEDURE PERFORMED

Data Format [combo] single-choice

Definition

Indicates whether there are ICD-9 codes for procedures to report or not

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- No
- Yes

Data Source

- Operative Reports
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

Additional Information

- Code the field as Not Applicable if patient did not have procedures

National & State Element

ICD-9 CODE (Hospital Procedures)*

Data Format [combo]multiple-choice

Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications.

The list of procedures below should be used as a guide to non operative procedures that should be provided to the state. Not all hospitals capture all procedures listed below. Please transmit those procedures that you capture to the state.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*HospitalProcedure*
Multiple Entry Configuration	Yes, max 200	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Major and minor procedure ICD-9-CM procedure codes
- The maximum number of procedures that may be reported for a patient is 200

Additional Information

- Include only procedures performed at your institution
- Capture all procedures performed in the operating room
- Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- Note that the hospital may capture additional procedures
- Select "Not Applicable" for the Procedure Performed (TR22.30) variable if patient did not have procedures
- The null value "Not Known / Not Recorded" is used if not coding ICD-9.

Data Source

- Operative Reports
- ER and ICU Records
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

Diagnostic & Therapeutic Imaging

Computerized tomographic studies *
Diagnostic ultrasound (includes FAST) *
Doppler ultrasound of extremities*
Angiography
Angioembolization
Echocardiography
Cystogram
IVC filter
Urethrogram

Cardiovascular

Central venous catheter *
Pulmonary artery catheter *
Cardiac output monitoring *
Open cardiac massage
CPR

CNS

Insertion of ICP monitor *
Ventriculostomy *
Cerebral oxygen monitoring *

Gastrointestinal

Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
Gastrostomy / jejunostomy (percutaneous or endoscopic)
Percutaneous (endoscopic) gastrojejunoscopy

Musculoskeletal

Soft tissue / bony debridements *
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

Genitourinary

Ureteric catheterization (i.e. Ureteric stent)
Suprapubic cystostomy

Transfusion

The following blood products should be captured over first 24 hours after hospital arrival:
Transfusion of red cells *
Transfusion of platelets *
Transfusion of plasma *
In addition to coding the individual blood products listed above assign the 99.01 ICD-9 procedure code on patients that receive > 10 units of blood products over first 24 hours following hospital arrival *
For pediatric patients (age 14 and under), assign 99.1 ICD-9 procedure code on patients that receive 40cc/kg of blood products over first 24 hours following hospital arrival*

Respiratory

Insertion of endotracheal tube *
Continuous mechanical ventilation *
Chest tube *
Bronchoscopy *
Tracheostomy
Open cardiac massage
CPR

Other

Hyperbaric oxygen
Decompression chamber
TPN *

National Element

- National Element HP_01 from the 2015 National Trauma Data Standard

ICD-10 CODE (Hospital Procedures)*

Data Format [combo]multiple-choice

Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications.

The list of procedures below should be used as a guide to non-operative procedures that should be provided to the state. Not all hospitals capture all procedures listed below. Please transmit those procedures that you capture to the state.

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*HospitalProcedureIcd10*
Multiple Entry Configuration	Yes, max 200	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Major and minor procedure ICD-10-CM procedure codes
- The maximum number of procedures that may be reported for a patient is 200

Additional Information

- Include only procedures performed at your institution
- Capture all procedures performed in the operating room
- Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- Note that the hospital may capture additional procedures
- Select "Not Applicable" for the Procedure Performed (TR22.30) variable if patient did not have procedures
- The null value "Not Known / Not Recorded" is used if not coding ICD-10.

Data Source

- Operative Reports
- ER and ICU Records
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

Diagnostic & Therapeutic Imaging

Computerized tomographic studies *
Diagnostic ultrasound (includes FAST) *
Doppler ultrasound of extremities*
Angiography
Angioembolization
Echocardiography
Cystogram
IVC filter
Urethrogram

Cardiovascular

Central venous catheter *
Pulmonary artery catheter *
Cardiac output monitoring *
Open cardiac massage
CPR

CNS

Insertion of ICP monitor *
Ventriculostomy *
Cerebral oxygen monitoring *

Gastrointestinal

Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)
Gastrostomy / jejunostomy (percutaneous or endoscopic)
Percutaneous (endoscopic) gastrojejunoscopy

Musculoskeletal

Soft tissue / bony debridements *
Closed reduction of fractures
Skeletal and halo traction
Fasciotomy

Genitourinary

Ureteric catheterization (i.e. Ureteric stent)
Suprapubic cystostomy

Transfusion

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For pediatric patients (age 14 and under), assign 99.01 ICD-9 procedure code on patients that receive 40cc/kg of blood products over first 24 hours following hospital arrival*

Respiratory

Insertion of endotracheal tube *
Continuous mechanical ventilation *
Chest tube *
Bronchoscopy *
Tracheostomy

Other

Hyperbaric oxygen
Decompression chamber
TPN *

National Element

- National Element HP_02 from the 2015 National Trauma Data Standard

(Procedure Performed) LOCATION

Data Format [combo] single-choice

Definition

The hospital location where the procedure was performed

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Catherization Lab
- ED
- Floor
- GI Lab
- ICU
- OR
- Prehospital
- PTA (Referring Hospital)
- Radiology
- Readmit OR (planned OR)
- Special Procedures Unit
- Tele

Data Source

- Operative Reports
- Triage Form / Trauma Flow Sheet
- Nurses' Documentation
- Physician Documentation
- Anesthesia Record
- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Discharge Summary

National & State Element

(Hospital Procedure) DATE STARTED*

Data Format [date]

Definition

The date operative and selected non-operative procedures were performed

XSD Data Type	*xs: date*	**XSD Element / Domain (Simple Type)** *HospitalProcedureStartDate*	
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record
- Procedure Notes
- Trauma Flow Sheet
- ED Record
- Radiology Reports
- Discharge Summary

National Element

- National Element HP_03 from the 2015 National Trauma Data Standard

National & State Element

(Hospital Procedure Start) TIME*

Data Format [time]

Definition

The time operative and selected non-operative procedures were performed

XSD Data Type	*xs: time*	**XSD Element / Domain (Simple Type)** *HospitalProcedureStartTime*	
Multiple Entry Configuration	Yes	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Procedure start time is defined as the time the incision was made (or the procedure started)
- If distinct procedures with the same procedure code are performed, their start times must be different

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record
- Procedure Notes
- Trauma Flow Sheet
- ED Record
- Radiology Reports
- Discharge Summary

National Element

- National Element HP_04 from the 2015 National Trauma Data Standard

(Physician Performing the Procedure) STAFF

Data Format [combo] single-choice

Definition

Physician performing the procedure

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

SERVICE TYPE (of the Physician)

Data Format [combo] single-choice

Definition

Service type of the physician

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Critical Care Medicine
- Emergency Medicine
- Ear Nose Throat
- Gastroenterology
- Gynecology
- General Surgery
- Hand Surgery
- Medicine
- Neurosurgery
- Obstetrics
- Oral Maxillo Facial Surgery
- Ophthalmology
- Orthopedic Surgery
- Pediatric Surgery
- Pediatric Orthopedic
- Plastic Surgery
- Radiology
- Trauma Surgery
- Thoracic Surgery
- Urology
- Vascular Surgery

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

(Procedure) COMMENTS

Data Format [text]

Definition

Additional information about the procedure

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

RESOURCE UTILIZATION

Data Format [combo] single-choice

Definition

A list of resources used during the treatment and care of the patient

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Adult Protective Service
- Bi-Pap
- Case Management
- Cerebral Brain Flow Studies
- Child Protective Service
- CRRT
- Dialysis
- Epidural Catheter
- Exceeds LOS
- Factor VIIa (Novoseven)
- High dose methylprednisolone
- Hypertonic Saline
- Level-1 Blood/Fluid Warmer
- LiCox Monitor
- Massive Blood Transfusion
- Miama J Collar
- MRI
- None
- Nutritionist
- Occupational Therapy
- Pentobarbital Coma
- Peripheral Parenteral Nutrition (PPN)
- Physical Therapy
- PICC line
- PRISMA (CVVHD)
- Respiratory Therapy
- RN accompanied transfer
- Specialized Bed
- Speech Therapy
- TLSO Brace
- Total Parenteral Nutrition (TPN)
- Traction
- Transfusion of FFP
- Transfusion of Platelets
- Transfusion of PRBC
- Tube Feeding
- Uncrossmatched Blood
- Vaccine Post-Splenectomy
- Venous Doppler
- Wound Care RN
- Wound Vacuum

Data Source

- OR Nurses' Notes
- Operative Reports
- Anesthesia Record

Complications / Performance Improvement Information

(Hospital) COMPLICATIONS*

Data Format [combo] single-choice

Definition

Any medical complication that occurred during the patient's stay at your hospital

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*HospitalComplications*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Cardiovascular
- Gastrointestinal
- Hematologic
- Hepatic, Pancreatic, Biliary, Splenic
- Hospital Airway
- Infection (Nonpulmonary, Nonorthopedic)
- Miscellaneous
- Musculoskeletal / Integumentary
- Neurologic
- No Complications
- Prehospital Airway
- Prehospital Fluids
- Prehospital Miscellaneous
- Provider Errors/Delays
- Psychiatric
- Pulmonary
- Renal/Genitourinary
- Vascular

Additional Information

- The value "Not Applicable" can also be used for patients with no complications
- Refer to Appendix 3: National Glossary of Terms for definitions of Complications
- Select all that apply

National Element

- National Element Q_01 from the 2015 National Trauma Data Standard

(Hospital) COMPLICATIONS (Sub Categories)*

Data Format [combo] single-choice

Definition

Any medical complication that occurred during the patient's stay at your hospital

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*HospitalComplication*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

Cardiovascular

- ~~RETIRED 2011 Base Deficit~~
- ~~RETIRED 2011 Bleeding~~

8 Cardiac Arrest with resuscitative efforts by healthcare provider

18 Myocardial infarction

Gastrointestinal

- ~~RETIRED 2011 Abdominal Compartment Syndrome~~
- ~~RETIRED 2011 Abdominal Fascia~~
- Wound Disruption

Hematologic

- ~~RETIRED 2011 Coagulopathy~~

Hepatic, Pancreatic, Biliary, Splenic

- Splenic Injury (Iatrogenic)
- Pancreatitis
- Pancreatic Fistula
- Other Hepatic / Biliary
- Liver Failure
- Jaundice
- Hepatitis
- Acalculous Cholesystitis

Hospital Airway

Miscellaneous

30 Unplanned return to the OR

31 Unplanned return to the ICU

Musculoskeletal/Integumentary

11 Decubitus Ulcer

15 Extremity compartment syndrome

29 Osteomyelitis

Neurologic

- ~~RETIRED 2011 Coma~~

13 Drug or alcohol withdrawal syndrome

- ~~RETIRED 2011 Intracranial pressure~~

22 Stroke / CVA

Prehospital Airway

- Unable to intubate
- Mainstem Intubation
- Extubation, Unintentional
- Esophageal Intubation
- Aspiration

Pulmonary

5 Acute lung injury/Acute respiratory distress syndrome (ARDS)

25 Unplanned Intubation

Infection (Nonpulmonary, nonorthopedic)

32 ~~RETIRED 2011 Severe Sepsis~~

28 Catheter - Related Blood Stream Infection

12 Deep surgical site infection

19 Organ/space surgical site infection

23 Superficial surgical site infection

- Systemic Sepsis

Prehospital Fluids

- Unable to start IV
- Inappropriate Fluid Management

Prehospital Miscellaneous

- Other prehospital fluid

20 Pneumonia

21 Pulmonary embolism

Renal / Genitourinary

4 Acute kidney failure

27 Urinary Tract Infection

Vascular

14 Deep Vein Thrombosis (DVT) / thrombophlebitis

16 Graft/prosthesis/flap failure

Provider Errors/Delays

Psychiatric

Other

No Complications

- No Complications

Additional Information

- *A number indicates complications recognized by the NTDB.*
- The value "No Complications" should be used for patients with no complications.
- Refer to Appendix 3: National Glossary of Terms for definitions of complications.
- Select all that apply.

Data Source Hierarchy

- Discharge Sheet
- History and Physical
- Billing Sheet
- Physician Notes
- Operative Report
- Progress Notes
- Radiology Report
- Respiratory Notes
- Lab Reports
- Nursing Notes/Flow

National Element

- National Element Q_01 from the 2015 National Trauma Data Standard

(Complication) STATUS

Data Format [radio]

Definition

The status of the complication

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Open
- Close

(Complication) OCCURRENCE DATE

Data Format [date]

Definition

The date that the complication was first documented

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Complication) OCCURRENCE TIME

Data Format [time]

Definition

The time that the complication was first documented

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(Complication) LOCATION OF OCCURRENCE

Data Format [combo] single-choice

Definition

The location that the complication occurred

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Burn Unit
- Catherization Lab
- ED
- Floor Bed
- GI Lab
- ICU
- OR
- Pre-Hospital
- PTA (Referring Hospital)
- Radiology
- Readmit OR (planned OR)
- Telemetry / Step-Down Unit

COMPLICATION STAFF INVOLVED

Data Format [combo]multiple-choice

Definition

Staff involved with the complication

Multiple Entry Configuration	Yes	**Accepts Null Value**	No

Field Values

- Relevant value for data element

Additional Information

- Press and hold "CTRL" key to select multiple values

(Complication) PR DATE

Data Format [date]

Definition

Complications peer review date

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(Complication) PR TIME

Data Format [time]

Definition

Complications peer review time

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(Complication) CORRECTIVE ACTION

Data Format [combo] single-choice

Definition

The action taken based on the complication

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Counseling
- Education
- Guideline / Protocol
- Not Indicated
- Other
- Peer Review Presentation
- Privilege/Credentiating
- Process Improvement Team
- Resource Enhancement
- Trend
- Unnecessary

(Complication) OTHER CORRECTIVE ACTION

Data Format [text]

Definition

Any other action taken based on the complication

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Corrective Action is "Other"

(Complication) DETERMINATION

Data Format [combo] single-choice

Definition

Indication as to what was determined to cause the complication

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Cannot be Determined
- Disease-Related
- Procedure-Related
- Provider-Related
- System-Related

FURTHER EXPLAINATION / ACTION (of Complication)

Data Format [text]

Definition

Further explanation of the complication

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 2000

Field Values

- Relevant value for data element

PREVENTABILITY (of Complication)

Data Format [combo] single-choice

Definition

Is the complication preventable?

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Cannot Be Determined
- Non-preventable
- Potentially Preventable
- Preventable

JUDGMENT (of Complication)

Data Format [combo] single-choice

Definition

Outcome of peer review of a complication

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Acceptable
- Acceptable with Reservations
- Defer Peer Review
- Unacceptable
- Will Never Undergo PR

(COMPLICATION CORRESPONDENCE) STAFF

Data Format [combo] single-choice

Definition

Staff involved with the complication correspondence

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Relevant value for data element

(COMPLICATION CORRESPONDENCE) NOTE

Data Format [text]

Definition

Complication correspondence note

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 2000

Field Values

- Relevant value for data element

(Complication Correspondence) SOURCE

Data Format [combo] single-choice

Definition

Complication correspondence source

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Autopsy
- Conversation
- Daily Rounds
- EMS Run Sheet
- Hospital Quality Department
- Medical Record
- Patient/Family Concern/Comment
- PI Comm
- Referrals
- Risk Management Variance report
- Staff Concern

(Complication Correspondence) TYPE

Data Format [combo] single-choice

Definition

Complication correspondence type

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Action Plan
- Care Concern
- Primary Review
- Process Concern
- Secondary Review
- Tertiary Review

(Complication Correspondence) GROUP

Data Format [combo] single-choice

Definition

Complication correspondence group

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Neuro
- Ortho
- Other
- Peds
- Trauma

PERFORMANCE IMPROVEMENT AUDITS

Data Format [combo] single-choice

Definition

The performance improvement audit

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- No Performance Improvement Issues
- 2 hours at initial hospital before transfer (State)
- Delay in Assessment, Diagnosis, Technique, Disposition, or Treatment
- Hospital Specific PI
- No FAST exam performed
- < = 8 GCS and no definitive airway established
- Abdominal, Thoracic, Vascular, or Cranial Surgery After 24 hours
- Absent hourly charting
- Admit by Non-surgeon
- Airway Complication
- Ambulance Scene Time > 20 minutes
- Appropriateness of Prehospital and ED Triage
- Appropriateness , Completeness, and Legibility of Documentation
- Availability of Family Services
- Carbon Monoxide Poisoning
- Cardiac / Respiratory Arrest *After* Admission
- Cardiac / Respiratory Arrest *Prior* Admission
- Compliance with Guidelines, Protocols, and Pathways
- Consistency of Outpatient Follow-up
- Craniotomy After 4 Hrs., with Epidural or Subdural, Excluding ICP Monitoring
- Deaths (*Hospital*)
- Deaths (*Pre-Hospital*)
- Delay to OR or Availability of OR - Acute or Subacute
- Door to backboard removal > 30 minutes
- ER Temperature not recorded for patients < 12 years of age
- Error in Judgment, Communication, Diagnosis, Technique, or Treatment
- Glasgow Coma Score (GCS) < 14, No Head CT

- GCS < =8, no Endotracheal Tube or Surgical Airway
- GCS not present (*Hospital*)
- GCS not present (*Pre-hospital*)
- Initial rX > 8 Hrs of Open Tibia Fx, Exc. Low Velocity Gunshot Wound
- Intubated and end tidal CO2 not documented
- Laparotomy after 4 Hours
- Missing EMS Report
- NARSIS or EMS Form/Run Select/Electronic Report Not Available
- No Laparotomy <=1 Hour, Abdominal Injuries, and Systolic BP < 90
- Nonfixation of Femoral Diaphyseal Fracture in Adult (ACSAF10)
- Nonoperative rX of Gunshot Wound to the Abdomen (ACSAF4)
- Not Available
- Pain assessment not recorded hourly
- Pain level persistently > 5
- Peripheral Nerve Injury During Injury or Care
- Physician or Physician extender response > 30 min in level III Trauma Center
- Physician or Physician extender response > 15 min in level I or II Trauma Center
- Professional Behavior
- Reintubation within 48 hours of Extubation
- Response Time > 30 minutes (dispatch to arrival on scene)
- Skin Graft Loss Requiring Regrafting
- Timeliness and availability of X-Ray Reports
- Timeliness of Rehabilitation
- Timely Participation of Subspecialists (Delay in Trauma Activation, Obtaining Consultation, or MD Response)
- Transferred and did not meet transfer criteria
- Vital signs not recorded (*Hospital*)
- Vital signs not recorded (*Pre-Hospital*)
- Volume of infused fluids not documented

(Performance Improvement) STATUS

Data Format [radio]

Definition

The status of the QA peer review judgement

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Open
- Close

(PI) OCCURRENCE DATE

Data Format [date]

Definition

The date that the performance improvement occurred

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(PI) OCCURRENCE TIME

Data Format [time]

Definition

The time that the performance improvement audit occurred

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(PI) LOCATION OF OCCURRENCE

Data Format [combo] single-choice

Definition

The location that the performance improvement audit occurred

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Burn Unit
- Catherization Lab
- ED
- Floor Bed
- GI Lab
- ICU
- OR
- Pre-Hospital
- PTA (Referring Hospital)
- Radiology
- Readmit OR (planned OR)
- Telemetry / Step-Down Unit

AUDIT STAFF INVOLVED

Data Format [combo]multiple-choice

Definition

Staff involved with the complication

Multiple Entry Configuration	Yes	**Accepts Null Value**	No

Field Values

- Relevant value for data element

Additional Information

- Press and hold "CTRL" key to select multiple values

(PI) PR DATE

Data Format [date]

Definition

The QA indicator peer review date

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY

(PI) PR TIME

Data Format [time]

Definition

The QA indicator peer review time

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM

(PI) CORRECTIVE ACTION

Data Format [combo] single-choice

Definition

The action taken based on the quality indicator

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Counseling
- Education
- Guideline / Protocol
- Other
- Peer Review Presentation
- Privilege/Credentiating
- Process Improvement Team
- Resource Enhancement
- Trend
- Unnecessary

DETERMINATION (of PI)

Data Format [combo] single-choice

Definition

Indication as to what was determined to cause the need for a performance improvement audit

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Cannot be Determined
- Disease-Related
- Provider-Related
- System-Related

FURTHER EXPLANATION / ACTION (of PI)

Data Format [text]

Definition

Further explanation of the PI

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 2000

Field Values

- Relevant value for data element

(PI) PREVENTABILITY

Data Format [combo] single-choice

Definition

Is the PI preventable?

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Cannot Be Determined
- Nonpreventable
- Potentially Preventable
- Preventable

(PI) JUDGMENT

Data Format [combo] single-choice

Definition

Peer review judgment of a QA indicator

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Acceptable
- Acceptable with Reservations
- Defer Peer Review
- Not Available
- Not Recorded
- Unacceptable
- Will Never Undergo PR

(PI CORRESPONDENCE) STAFF

Data Format [combo] single-choice

Definition

Staff involved with the performance improvement audit correspondence

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Relevant value for data element

(PI CORRESPONDENCE) NOTE

Data Format [text]

Definition

Performance Improvement audit correspondence note

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
		Min. Constraint: 0	**Max. Constraint:** 2000

Field Values

- Relevant value for data element

(PI Correspondence) SOURCE

Data Format [combo] single-choice

Definition

Performance Improvement audit correspondence source

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Autopsy
- Conversation
- Daily Rounds
- EMS Run Sheet
- Hospital Quality Department
- Medical Record
- Patient/Family Concern/Comment
- PI Comm
- Referrals
- Risk Management Variance report
- Staff Concern

(PI Correspondence) TYPE

Data Format [combo] single-choice

Definition

Performance Improvement audit correspondence type

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Action Plan
- Care Concern
- Primary Review
- Process Concern
- Secondary Review
- Tertiary Review

(PI Correspondence) GROUP

Data Format [combo] single-choice

Definition

Performance Improvement audit correspondence group

Multiple Entry Configuration	No	**Accepts Null Value**	No

Field Values

- Neuro
- Ortho
- Other
- Peds
- Trauma

Outcome Information

HOSPITAL DISCHARGE SERVICE

Data Format [combo] single-choice

Definition

The department that discharged the patient from the hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Critical Care Medicine
- Gynecology
- Neurosurgery
- Orthopedic Surgery
- Acute Rehabilitation Medicine
- Vascular Surgery
- Gastroenterology
- Bariatric
- Ophthalmology
- Plastic Surgery
- Urology
- Dermatology
- Geriatric
- Infectious Disease
- Kidney Transplant
- Neonatal
- Neurology
- Pediatric Cardiology
- Pediatric Dentistry
- Pediatric Hematology Oncology
- Pediatric Nephrology
- Pediatric Pulmonary
- Liver
- Nephrology
- Pediatric Critical Care Medicine
- Pediatric Infectious Disease
- Pediatric Nephrology
- Rheumatology
- Ear Nose Throat
- Hand
- Oral Maxillo Facial Surgery
- Pediatric Orthopedic
- Cardiology
- Chemical Dependency
- General Surgery
- Obstetrics
- Critical Care Surgery
- Trauma Surgeon
- Psychiatry
- Pulmonary
- Anesthesia
- Burn
- Cardiothoracic Surgery
- Dentistry
- Endocrinology
- Family Medicine
- Gynecology
- Hematology Oncology
- Internal Medicine
- Occuloplastic
- Pain
- Pediatric Gastroenterology
- Pediatric Neurology
- Psychology

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

HOSPITAL ADMISSION DATE

Data Format [date]

Definition

Date patient was discharged from the ED (or arrived at the facility if the patient was a direct admit)

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated field: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

Optional State Element

HOSPITAL ADMISSION TIME

Data Format [time]

Definition

Time patient was discharged from the ED (or arrived at the facility if the patient was a direct admit)

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total Length of Hospital Stay (time from hospital admission to hospital discharge)

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

National & State Element

HOSPITAL DISCHARGE DATE*

Data Format [date]

Definition

The date the patient was discharged from the hospital

XSD Data Type	*xs: date*	**XSD Element / Domain (Simple Type)**	*HospitalDischargeDate*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1990	**Max. Constraint:** 2030

Field Values

- Relevant value for data element

Additional Information

- Collected as MM/DD/YYYY
- Used to auto-generate an additional calculated field: Total Length of Hospital Stay (time from hospital admission to hospital discharge)
- Leave value blank if the null value should be "Not Applicable" if ED Discharge Disposition is "Died"
- Leave value blank if the null value should be "Not Applicable" if ED Discharge Disposition is "Home with Services", "Other (jail, institutional care, mental health, etc.)", "Home without Services", "Left against medical advice", or "Transferred to another hospital"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Nursing Notes / Flow Sheet
- Case Management / Social Services Notes

National Element

- National Element O_03 from the 2015 National Trauma Data Standard

National & State Element

TR 25.48

HOSPITAL DISCHARGE TIME*

Data Format [time]

Definition

The time the patient was discharged from the hospital

XSD Data Type	*xs: time*	**XSD Element / Domain (Simple Type)**	*HospitalDischargeTime*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 00:00	**Max. Constraint:** 23:59

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM
- HHMM should be collected as military time
- Used to auto-generate an additional calculated field: Total Length of Hospital Stay (time from hospital admission to hospital discharge)
- Leave value blank if the null value should be "Not Applicable" if ED Discharge Disposition is "Died"
- Leave value blank if the null value should be "Not Applicable" if ED Discharge Disposition is "Home with Services", "Other (jail, institutional care, mental health, etc.)", "Home without Services", "Left against medical advice", or "Transferred to another hospital"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Nursing Notes / Flow Sheet
- Case Management / Social Services Notes

National Element

- National Element O_04 from the 2015 National Trauma Data Standard

TOTAL ICU DAYS*

Data Format [number]

Definition

The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)**	*TotalICuLos*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 400

Field Values

- Relevant value for data element

Additional Information

- Recorded in full day increments with any partial day listed as a full calendar day
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart
- If any dates are missing then a LOS cannot be calculated
- If patient has multiple ICU episodes on the same calendar day, count that day as one calendar day
- At no time should the ICU LOS exceed the Hospital LOS
- If the patient had no ICU days according to the above definition, code as "Not Applicable"

Data Source

- ICU Nursing Flow Sheet
- Calculate Based on Admission Form and Discharge Sheet
- Nursing Progress Notes

National Element

- National Element O_01 from the 2015 National Trauma Data Standard

National Element

TR 26.58

TOTAL VENTILATOR DAYS*

Data Format [number]

Definition

The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day.

XSD Data Type *xs: integer*		**XSD Element / Domain (Simple Type)** *TotalVentDays*	
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes	**Min. Constraint:** 1	**Max. Constraint:** 400

Field Values

- Relevant value for data element

Additional Information

- Excludes mechanical ventilation time associated with OR procedures
- Non-invasive means of ventilator support (CPAP or BIPAP) should not be considered in the calculation of ventilator hours
- Recorded in full day increments with any partial day listed as a full day
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart
- If any dates are missing then a Total Vent Days cannot be calculated
- At no time should the Total Vent Days exceed the Hospital LOS
- Leave value blank if the null value should be "Not Applicable" if the patient was not on the ventilator according to the above definition.

Data Source

- ICU Respiratory Therapy Flow Sheet
- ICU Nursing Flow Sheet
- Physician's Daily Progress Notes
- Calculate Based on Admission Form and Discharge Sheet
- Nursing Progress Notes

National Element

- National Element O_02 from the 2015 National Trauma Data Standard

PRIMARY METHOD OF PAYMENT *

Data Format [combo] single-choice

Definition

Primary source of payment for hospital care

XSD Data Type	*xs: string*	**XSD Element / Domain (Simple Type)**	*PrimaryMethodPayment*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Medicaid
2 Not Billed (for any reason)
3 Self Pay
4 Private / Commercial Insurance ~~RETIRED 2015 (No Fault)~~
5 ~~Automobile~~
6 Medicare
7 Other Government
8 ~~REITRED 2015 Workers Compensation~~ ~~RETIRED 2015 Blue Cross / Blue~~
9 ~~Shield~~
10 Other

Additional Source

- No Fault Automobile, Workers Compensation, and Blue Cross/Blue Shield should be captured as Private/Commercial Insurance.

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form
- Face Sheet

National Element

- National Element F_01 from the 2015 National Trauma Data Standard

OTHER BILLING SOURCE

Data Format [text]

Definition

Other billing source that is not specific in the Primary Method of Payment drop-down menu

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Primary Method of Payment is "Other"

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form
- Face Sheet

SECONDARY METHOD OF PAYMENT

Data Format [combo] single-choice

Definition

Any known secondary source of finance expected to assist in payment of medical bills

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Medicare Supp
- Managed Care
- No Fault Automobile
- Not Billed (for any reason)
- Medicare
- Medicaid
- Private / Commercial Insurance
- Workers Compensation
- Other
- Self Pay
- Other Government

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form
- Face Sheet

SECONDARY OTHER BILLING SOURCE

Data Format [text]

Definition

Secondary other billing source that is not specific in the Secondary Method of Payment drop-down menu

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Secondary Method of Payment is "Other"

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form
- Face Sheet

National & State Element

WORK-RELATED*

Data Format [combo] single-choice

Definition

Indication of whether the injury occurred during paid employment

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*WorkRelated*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Yes

2 No

Additional Information

- If work related, two additional data fields must be completed: Patient's Occupational Industry and Patient's Occupation

Data Source

- EMS Run Sheet
- Triage Form / Trauma Flow Sheet
- ED Nurses' Notes
- Other ED Documentation
- Face Sheet
- History & Physical
- Billing Sheet

National Element

- National Element I_03 from the 2015 National Trauma Data Standard

National & State Element

PATIENT'S OCCUPATIONAL INDUSTRY*

Data Format [combo] single-choice

Definition

The occupational industry associated with the patient's work environment

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	
Multiple Entry Configuration	No	*PatientsOccupationalIndustry*	
Required in XSD	Yes	**Accepts Null Value**	Yes, common null values

Field Values

1 Finance, Insurance, and Real Estate
2 Manufacturing
3 Retail Trade
4 Transportation and Public Utilities
5 Agriculture, Forestry, Fishing
6 Professional and Business Services
7 Education and Health Services
8 Construction
9 Government
10 Natural Resources and Mining
11 Information Services
12 Wholesale Trade
13 Leisure and Hospitality
14 Other Services

Additional Information

- If work related, also complete Patient's Occupation
- Based upon US Bureau of Labor Statistics Industry Classification

Data Source

- Triage Form / Trauma Flow Sheet
- EMS Run Sheet
- ED Nurses' Notes
- Other ED Documentation
- Face Sheet
- Case Management / Social Services Notes

National Element

- National Element I_04 from the 2015 National Trauma Data Standard

National & State Element

PATIENT'S OCCUPATION*

Data Format [combo] single-choice

Definition

The occupation of the patient

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*PatientsOccupation*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

1 Business and Financial Operations Ocp
2 Architecture and Engineering Ocp
3 Community and Social Services Ocp
4 Education, Training, and Library Ocp
5 Healthcare Practitioners and Technical Ocp
6 Protective Service Ocp
7 Building and Grounds Cleaning and Maintenance
8 Sales and Related Ocp
9 Farming, Fishing, and Forestry Ocp
10 Installation, Maintenance, and Repair Ocp
11 Transportation and Material Moving Ocp
12 Management Ocp
13 Computer and Mathematical Ocp
14 Life, Physical, and Social Science Ocp
15 Legal Ocp
16 Arts, Design, Entertainment, Sports, and Media
17 Healthcare Support Ocp
18 Food Prep & Serving Related
19 Personal Care & Service Ocp
20 Office & Admin Support Ocp
21 Construction and Extraction Ocp
22 Production Ocp
23 Military Specific Ocp

Additional Information

- Only completed if injury is work-related
- If work related, also complete Patient's Occupational Industry
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC)

Data Source

- Triage Form / Trauma Flow Sheet
- EMS Run Sheet
- ED Nurses' Notes
- Other ED documentation
- Face Sheet
- Billing Sheet

National Element

- National Element I_05 from the 2015 National Trauma Data Standard

BILLED HOSPITAL CHARGES

Data Format [number]

Definition

The total amount the hospital charged for the patient's care

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

REIMBURSED CHARGES

Data Format [number]

Definition

The amount the hospital was reimbursed for services

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

DISABILITY AT DISCHARGE - FEEDING

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of trauma patient feeding disability at discharge from an acute care facility

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*SelfFeeding*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

1	Dependent - Total Help	2	Dependent - Partial Help
3	Independent with Device	4	Independent

Additional Information

- Used to auto-generate an additional calculated field: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Assess as close to discharge as possible. Includes using suitable utensils to bring food to mouth, chewing, and swallowing (once meal is appropriately prepared). Opening containers, cutting meat, buttering bread and pouring liquids are not included as they are often part of meal preparation.
- Dependent-total help required: Either performs less than half of feeding tasks, or does not eat or drink full meals by mouth and relies at least in part on other means of alimentation, such as parenteral or gastrostomy feedings.
- Dependent-partial help required: Performs half or more of feeding tasks but requires supervision (e.g., standby, cueing, or coaxing) setup (application of Orthopedics), or other help.
- Independent with device: Uses an adaptive or assisting device such as a straw, spork, or rocking knifes, or requires more than a reasonable time to eat.
- Independent: Eats from a dish and drinks from a cup or glass presented in the customary manner on table or tray. Uses ordinary knife, fork, and spoon.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

DISABILITY AT DISCHARGE - LOCOMOTION

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of trauma patient locomotion (independence) disability at discharge from an acute care facility

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Locomotion*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

1 Dependent - Total Help
2 Dependent - Partial Help
3 Independent with Device
4 Independent

Additional Information

- Used to auto-generate an additional calculated field: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes walking once in a standing position, or using a wheelchair, once in a seated position, indoors
- Dependent - total help required: Performs less than half of locomotion effort to go a minimum of 50 feet, or does not walk or wheel a minimum of 50 feet. Requires assistance of one or more persons.
- Dependent - partial help required: If walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet, or walks independently only short distances (a minimum of 50 feet). If not walking, requires standby supervision, cueing, or coaxing to go a minimum of 150 feet in wheelchair, or operates manual or electric wheelchair independently only short distances (a minimum of 50 feet).
- Independent with Device: Walks a minimum of 150 feet but uses a brace or prosthesis on leg, special adaptive shoes, cane, crutches, or walker; takes more than a reasonable time; or there are safety considerations. If not walking, operates manual or electric wheelchair independently for a minimum of 150 feet; turns around; maneuvers the chair to a table, bed, toilet; negotiates at least a 3% grade; maneuvers on rugs and over doorsills.
- Independent: Walks a minimum of 150 feet without assisting devices. Does not use a wheelchair. Performs safely.
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

DISABILITY AT DISCHARGE - EXPRESSION (MOTOR)

Data Format [combo] single-choice

Definition

A score calculated to derive a baseline of trauma patient motor (expression) disability at discharge from an acute care facility

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Expression*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

1	Dependent - Total Help	2	Dependent - Partial Help
3	Independent with Device	4	Independent

Additional Information

- Used to auto-generate an additional calculated field: FIM Score (combination of Feeding, Locomotion, and Motor scores)
- Includes clear expression of verbal or nonverbal language. This means expressing linguistic information verbally or graphically with appropriate and accurate meaning and grammar
- Dependent - total help required: Expresses basic needs and ideas less than half of the time. Needs prompting more than half the time or does not express basic needs appropriately or consistently despite prompting
- Dependent - partial help required: Expresses basic needs and ideas about everyday situations half (50%) or more than half of the time. Requires some prompting, but requires that prompting less than half (50%) of the time
- Independent with Device: Expresses complex or abstract ideas with mild difficulty. May require an augmentative communication device or system
- Independent: Expresses complex or abstract ideas intelligibly and fluently, verbal or nonverbal, including signing or writing
- Not applicable: (e.g., patient less than 7 years old, patient died, etc.)

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

DISABILITY AT DISCHARGE - FIM SCORE

Data Format [number]

Definition

A score calculated (by adding together the Feeding, Independence, and Motor scores) to derive a baseline of trauma patient disability at discharge from an acute care facility, using three components: Feeding, Locomotion (Independence), and Motor (Expression)

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element
- Auto-calculated by combining Feeding, Locomotion, and Motor scores when entered

Data Source

- Billing Sheet / Medical Records Coding Summary Sheet
- Hospital Admission Form

HOSPITAL DISCHARGE DISPOSITION*

Data Format [combo] single-choice

Definition

The disposition of the patient when discharged from the hospital

XSD Data Type	xs: integer	**XSD Element / Domain (Simple Type)**	
Multiple Entry Configuration	No	HospitalDischargeDisposition	
Required in XSD	Yes	**Accepts Null Value**	Yes, common null values

Field Values

1 Discharged/Transferred to a short-term general hospital for inpatient care
2 Discharged/Transferred to an Intermediate Care Facility (ICF)
3 Discharged/Transferred to home under care of organized home health service
4 Left against medical advice (AMA) or discontinued care
5 Expired
6 Discharged home with no home services
7 Discharged/Transferred to Skilled Nursing Facility (SNF)
8 Discharged/Transferred to hospice care
9 ~~RETIRED 2014 Discharged/Transferred to another type of rehabilitation or long-term care facility~~
10 Discharged/Transferred to court/law enforcement
11 Discharged/Transferred to inpatient rehab or designated unit
12 Discharged/Transferred to Long Term Care Hospital (LTCH)
13 Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
14 Discharged/Transferred to another type of institution not defined elsewhere

Additional Information

- *"Home" refers to the patient's current place of residence (e.g., prison, Child Protective Services, etc.)*
- Field values based upon UB-04 disposition coding
- **Disposition to any other non-medical facility should be coded as "Discharged home with no home services"**
- **Disposition to any other medical facility should be coded as "Discharged / Transferred to another type of institution not defined elsewhere"**
- Refer to Appendix 6: Indiana Glossary of Terms for definitions of facility types
- The null value "Not Applicable" is used if ED Discharge Disposition value is "Died"

- The null value "Not Applicable" is used if ED Discharge Disposition value is "Home with Services", "Other (jail, institutional care, mental health, etc.)", "Home without services", "Left against medical advice", or "Transferred to another hospital"

Data Source

- Hospital Records
- Physician Discharge Summary
- Nurses' Notes
- Billing Sheet / Medical Records Coding Summary Sheet
- Case Manager / Social Services' Notes

National Element

- National Element O_05 from the 2015 National Trauma Data Standard

LOCATION OF DEATH

Data Format [combo] single-choice

Definition

The location where the patient died

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- ICU
- Floor
- ER
- OR
- Prior to Arrival

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

DEATH CIRCUMSTANCE

Data Format [combo] single-choice

Definition

Indicates patient's primary cause of death

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Brain Injury
- Burn Shock
- Cardio Failure
- Drowning
- Electrocution
- Heart Laceration
- Liver Laceration
- Multiple Organ Failure/Metabolic
- Other
- Pre-Existing Illness
- Pulmonary Failure
- Pulmonary Failure/Sepsis
- Thoracic Aortic Transection
- Trauma Shock
- Treatment Withheld
- Brain Death
- Sepsis
- Cardiac Arrest due to Strangulation
- Cardiac Arrest
- Family D/C Life Support
- Medical
- Multisystem Trauma
- Trauma Wound

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Autopsy Report

OTHER (Death Circumstance) DESCRIPTION

Data Format [text]

Definition

The circumstance under which the patient died

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Death Circumstance is "Other"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary
- Autopsy Report

ORGAN DONATION

Data Format [combo] single-choice

Definition

To make a gift of a differentiated structure (as a heart, kidney, leaf, or stem) consisting of cells and tissues and performing some specific function in an organism

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*OrganDonation*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Yes
- No
- Tissue Donation

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Documentation

AUTOPSY

Data Format [combo] single-choice

Definition

An examination of a body after death to determine the cause of death or the character and extent of changes produced by disease

XSD Data Type	*xs: integer*	**XSD Element / Domain (Simple Type)**	*Autopsy*
Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values
Required in XSD	Yes		

Field Values

- Yes
- No

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Documentation

ADVANCED DIRECTIVE

Data Format [combo] single-choice

Definition

Advanced Directive

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Yes
- No

Additional Information

- Only completed if Hospital Disposition is "Expired"

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Hospital Outcome) DESTINATION DETERMINATION

Data Format [combo] single-choice

Definition

The reason the facility transferred this patient to another acute care hospital

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Hospital of Choice
- Specialty Resource Center

Additional Information

- Only completed if Hospital Disposition "Acute Care Hospital" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

HOSPITAL TRANSFERRED TO

Data Format [combo] single-choice

Definition

Name of the receiving facility the patient was transferred to

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Disposition "Acute Care Hospital", "Burn Care Facility", or "Rehab or long-term facility" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Other) FACILITY (Transferred to)

Data Format [text]

Definition

Any other identifying facility not found on the available list of options to which the patient was discharged

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Other) CITY (Transferred to)

Data Format [text]

Definition

The city in which the transfer facility is located

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Other) STATE (Transferred to)

Data Format [text]

Definition

The state in which the transfer facility is located

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Relevant value for data element

Additional Information

- Only completed if Hospital Transferred to "Other" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

(Discharge) TRANSPORT MODE

Data Format [combo] single-choice

Definition

Discharge transport mode

Multiple Entry Configuration	No	**Accepts Null Value**	Yes, common null values

Field Values

- Ambulance
- Helicopter
- Fixed Wing
- Police
- Private Vehicle

Additional Information

- Only completed if Hospital Disposition "Acute Care Hospital" is selected

Data Source

- Hospital Records
- Billing Sheet / Medical Records Coding Summary Sheet
- Physician Discharge Summary

Appendix 1: Auto Calculated Variables Based Upon Existing Data Elements

Variables Auto-Calculated Based on Existing Data Elements

1. *Trauma Registry Number (Data Element: TR5.12)*

   Definition: Number assigned by the registry software program or registrar that provides a unique identifier for a patient within a specific institution

   Calculation: Auto-Calculated

2. *Injury Intentionality (Data Element: TR20.11)*

   Definition: An indication of whether an injury was caused by an act carried out on purpose by oneself or by another person(s), with the goal of injuring or killing.

   Calculation: A matrix table grouping External Cause of Injury Codes (E-Codes) into two classifications: *mechanism* of injury or cause of death (e.g., falls, etc.) by *intent* of injury or manner of death (i.e., unintentional or "accidental", etc. [See Tables 1 and 2, pages 302-303). An electronic version of the CDC matrix may be viewed at: http://www.cdc.gov/injury/wisqars/ecode_matrix.html

3. *Trauma Type (Data Element: TR5.13)*

   Definition: An indication of the type (or nature) of trauma produced by an injury.

   Calculation: Injury diagnoses are categorized according to the Barell Matrix (See Tables 3 to 7, pages 304-308), a two-dimensional array of ICD-9-CM codes grouped by body region and nature of injury. An electronic version of the Barell Matrix may be viewed at: http://www.cdc.gov/nchs/data/ice/final_matrix_post_ice.pdf

4. *Inter-Facility Transfer (Data Element: TR25.54)*

   Definition: Was the patient transferred to your facility from another acute care facility?

   Calculation: TR16.22 – Arrived From is "Referring Hospital" and TR8.8 – Transported to Your Facility By is "EMS/Ground", "Helicopter/Air", or "Fixed Wing"

5. *Total EMS Response Time*

   Definition: The total elapsed time from dispatch of the EMS transporting unit to scene arrival of the EMS transporting unit (i.e., the time the vehicle stopped moving).

   Calculation: EMS Unit Arrival on Scene DateTime – EMS Dispatch DateTime

6. *Total EMS Scene Time*

Definition: The total elapsed time from EMS transporting unit scene arrival to EMS transporting unit scene departure (i.e., the time the vehicle started moving).

7. *Total EMS Time*

   Definition: The total elapsed time from dispatch of the EMS transporting unit to hospital arrival of the EMS transporting unit.

   Calculation: ED/Hospital Arrival DateTime – EMS Dispatch DateTime

8. *Overall GCS – EMS score (adult and pediatric)*

   Definition: A scale calculated in the pre-hospital setting which evaluates the patient's initial level of awareness, which indirectly indicates the extent of neurologic injury. The scale rates three categories of patient responses: eye opening, best verbal response, and best motor response. The lowest score is 3 and is indicative of no response; the highest score is 15 and indicates the patient is alert and aware of his or her surroundings.

   Calculation: Initial Field GCS Eye + Initial Field GCS Verbal + Initial Field GCS Motor

9. *Revised Trauma Score – EMS (adult and pediatric)*

   Definition: The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the pre-hospital setting.

   Calculation: RTS = 0.9368*(Initial Field GCS Total) + 0.7326*(Initial Field Systolic Blood Pressure) + 0.2908*(Initial Field Respiratory Rate)

10. *Overall GCS – Referring Hospital score (adult and pediatric)*

    Definition: A scale calculated at the referring hospital which evaluates the patient's initial level of awareness, which indirectly indicates the extent of neurologic injury. The scale rates three categories of patient responses: eye opening, best verbal response, and best motor response. The lowest score is 3 and is indicative of no response; the highest score is 15 and indicates the patient is alert and aware of his or her surroundings.

    Calculation: Referring Hospital GCS Eye + Referring Hospital GCS Verbal + Referring Hospital GCS Motor

11. *Revised Trauma Score – Referring Hospital (adult and pediatric)*

Definition: The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient at the referring hospital.

Calculation: RTS = 0.9368*(Referring Hospital GCS Total) + 0.7326*(Referring Hospital Systolic Blood Pressure) + 0.2908*(Referring Hospital Respiratory Rate)

12. *Total ED Time*

Definition: The total elapsed time the patient was in the emergency department (ED)

Calculation: ED Discharge DateTime – ED Arrival DateTime

13. *Overall GCS – ED score (adult and pediatric)*

Definition: A scale calculated in the ED or hospital setting which evaluates the patient's initial level of awareness, which indirectly indicates the extent of neurologic injury. The scale rates three categories of patient responses: eye opening, best verbal response, and best motor response. The lowest score is 3 and is indicative of no response; the highest score is 15 and indicates the patient is alert and aware of his or her surroundings.

Calculation: Initial ED/Hospital GCS Eye + Initial ED/Hospital GCS Verbal + Initial ED/Hospital GCS Motor

14. *Revised Trauma Score – ED (adult and pediatric)*

Definition: The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting.

Calculation: RTS = 0.9368*(Initial ED/Hospital GCS Total) + 0.7326*(Initial ED/Hospital Systolic Blood Pressure) + 0.2908*(Initial ED/Hospital Respiratory Rate)

15. *Abbreviated Injury Scale (six body regions)*

Definition: The Abbreviated Injury Scale (AIS) is an anatomical scoring system first introduced in 1969. Since this time it has been revised and updated against survival to provide a ranking of the severity of injury. AIS scores are available for six body regions: Head/Neck (*Data Element: TR21.2)*, Face (*Data Element: TR21.5*), Chest (*Data Element: TR21.3*), Abdominal (*Data Element: TR21.6*), Extremities (including pelvis) (*Data Element: TR21.4*), and External (*Data Element TR21.7*). The AIS is monitored by a scaling committee of the Association for the Advancement of Automotive Medicine.

Calculation: Injuries are ranked on a scale of 1 to 6, with 1 being minor, 5 severe and 6 an insurvivable injury. This represents the 'threat to life' associated with an injury and is not meant to represent a comprehensive measure of severity. The AIS is not a true scale, in that the difference between any two AIS scores is not the same as the difference between another set of two scores.

16. *Injury Severity Score (Data Element: TR21.8)*

Definition: The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries.

Calculation: Each injury is assigned an AIS score and is allocated to one of six body regions. The 3 most severely injured body regions have their AIS score squared and added together to produce the ISS score. Only the highest AIS score in each body region is used. The ISS score takes values from 0 to 75. If an injury is assigned an AIS of 6 (Insurvivable injury), the ISS score is automatically assigned to 75. An electronic version of this information may be viewed at: http://www.trauma.org/archive/scores/iss.html

17. *Probability of Survival (Data Element: TR21.9)*

Definition: The Trauma Score – Injury Severity Score (TRISS) determines the probability of survival (Ps) of a patient from the ISS, RTS, and patient's age.

Calculation: The following formula is used: $Ps = 1 / (1 + e^{-b})$

'b' is calculated from: $b = b0 + b1(RTS) + b2(ISS) + b3(AgeIndex)$.

b0 to b3 are coefficients derived from multiple regression analysis of the Major Trauma Outcomes Study (MTOS) database. The coefficients are different for blunt and penetrating trauma. If the patient is less that 15 years of age, the blunt coefficients are used regardless of the mechanism.

	Blunt	**Penetrating**
b0	-0.4499	-2.5355
b1	0.8085	0.9934
b2	-0.0835	-0.0651
b3	-1.7430	-1.1360

AgeIndex is 0 if the patient is below 54 years of age or 1 if 55 years of age and over. An electronic version of this information may be viewed at: http://www.trauma.org/archive/scores/triss.html

18. *New Injury Severity Score (Data Element: TR21.24)*

    Definition: As multiple injuries within the same body region are only assigned a single score, a proposed modification of ISS, the "New Injury Severity Score" (NISS), was proposed.

    Calculation: This is similar to how ISS is calculated, but NISS is calculated as the sum of the squares of the top three scores regardless of body region.

19. *Total Length of Hospital Stay (Data Element: TR25.44)*

    Definition: The total elapsed time the patient was in the hospital.

    Calculation: Hospital Discharge DateTime – ED/Hospital Arrival DateTime

Table 1: Modification of the Injury Intentionality CDC Matrix (Cut/Pierce to Overexertion)

	Manner/Intent				
Mechanism/Cause	**Unintentional**	**Self-inflicted**	**Assault**	**Undetermined**	**Other**
Cut/pierce	E920.0-.9	E956	E966	E986	E974, E995.2
Drowning / submersion	E830.0-.9 E832.0-.9 E910.0-.9	E954	E964	E984	E995.4
Fall	E880.0-E886.9 E888	E957.0-.9	E968.1	E987.0-.9	
Fire/burn	E890.0-E899 E924.0-.9	E958(.1,.2,.7)	E961 E968(.0,.3) E979.3	E988(.1,.2,.7)	
Fire/Flame	E890.0-E899	E958.1	E968.0 E979.3	E988.1	
Hot object / substance	E924.0-.9	E958.2 E958.7	E961 E968.3	E988.2 E988.7	
Firearm	E922.0-.3 E922(.8,.9)	E955.0-.4	E965.0-.4 E979.4	E985.0-.4	E970
Machinery	E919.0-.9				
Motor Vehicle Traffic	E810-E819(.0-.9)	E958.5	E968.5	E988.5	
Occupant	E810-E819(.0) E810-E819(.1)				
Motorcyclist	E810-E819(.2) E810-E819(.3)				
Pedal Cyclist	E810-819(.6)				
Pedestrian	E810-819(.7)				
Unspecified	E810-E819(.9)				
Pedal Cyclist, Other	E800-E807(.3) E820-E825(.6) E826.1,.9 E827-E829(.1)				
Pedestrian, Other	E800-E807(.2) E820-E825(.7) E826-E829(.0)				
Transport, Other	E800-E807(.0,.1,.8,.9) E820-E825(.0-.5,.8,.9) E826.2-.8 E827-E829(.2-.9) E831.0-.9 E833.0-E845.9	E958.6		E988.6	

Natural/Environmental	E900.00-E909 E928.0-.2	E958.3		E988.3	
Bites/Stings	E905.0-.6,.9 E906.0-.4,.5,.9				
Overexertion	E927.0-.4,.8,.9				

Table 2: Modification of the Injury Intentionality CDC Matrix (Poisoning to All External Causes)

	Manner/Intent				
Mechanism/Cause	**Unintentional**	**Self-inflicted**	**Assault**	**Undetermined**	**Other**
Poisoning	E850.0-E869.9	E950.0- E952.9	E962.0-.9 E979.6 E979.7	E980.0-E982.9	E972
Struck by, Against	E916-E917.9		E960.0 E968.2		E973 E975 (.0,.1)
Suffocation	E911-E913.9	E953.0-.9	E963	E983.0-.9	E995.3
Other Specified and Classifiable	E846-E848 E914-E915 E918 E921.0-.9 E922.4 E922.5 E923.0-.9 E925.0-E926.9 E928.3-.5 E929.0-.5	E955.5 E955.6 E955.7 E955.9 E958.0 E958.4	E960.1 E965.5-.9 E967.0-.9 E968.4,.6,.7 E979.0-.2, E979.5 E979.8 E979.9	E985.5 E985.6 E985.7 E988.0 E988.4	E971 E978 E990-E994 E996 E997.0-.2
Unspecified	E887 E928.9 E929.9	E958.9	E968.9	E988.9	E976 E997.9
All Injury	E800-E869 E880-E929	E950-E959	E960-E969 E979 E999.1	E980-E989	E970-E978 E990-E999.0
Adverse Effects					E870-E879 E930.0-E949.9
Medical Care					E870-879
Drugs					E930.0-e949.9
All external causes					E800-E999

Source: http://www.cdc.gov/injury/wisqars/ecode_matrix.html

Table 3: Modification of the Barell Injury Diagnosis Matrix, Classification by Body Region (Head and Neck) and Nature of the Injury

Head and Neck								
	Traumatic Brain Injury			Other Head, Face, and Neck				
	Type 1 TBI	Type 2 TBI	Type 3 TBI	Other Head	Face	Eye	Neck	Head, Face, & Neck Unspecified
Fracture 800-829	800,801,803 ,804(.1-.4, .6-.9) 800,801,803 ,804(.03-.05, .53-.55)	800,801,803 ,804(.00, .02,.06,.09) 800,801,803 ,804(.50, .52,.56,.59)	800.1 800.51 803.1 803.51 804.1 804.51	-	802	-	807.5 807.6	-
Dislocation 830-839	-	-	-	-	830	-	-	-
Sprains & Strains 840-848	-	-	-	-	848.0-.1	-	848.2	-
Internal 850-854 860-869 952 995.55	850(.2-.4) 851 852 853 854 995.55	850.0 850.1 850.5 850.9	-	-	-	-	-	-
Open Wound 870-884 890-894	-	-	-	873.0-.1, .8-.9	872 873.2-.7	870 871	874	-
Amputations 885-887 895-897	-	-	-	-	-	-	-	-
Blood Vessels 900-904	-	-	-	-	-	-	-	900
Contusion / Superficial 910-	-	-	-	-	-	918 921	-	910 920
Crush 925-929	-	-	-	-	-	-	925.2	925.1
Burns 940-949	-	-	-	941.x6	941.x1 941.x3-.x5 941.x7	940 941.x2	941.x8	941.x0 941.x9 947.0
Nerves 950-951 953-957	950(.1-.3)	-	-	951	-	950.0 950.9	953.0 954.0	957
Unspecified 959	-	-	-	959.01	-	-	-	959.09

Source: http://www.cdc.gov/nchs/data/ice/final_matrix_post_ice.pdf

Table 4: Modification of the Barell Injury Diagnosis Matrix, Classification by Body Region (Spine and Back) and Nature of the Injury

Spine and Back										
	Spinal Cord (SCI)					Vertebral Column (VCI)				
	Cervical SCI	Thoracic / Dorsal SCI	Lumbar SCI	Sacrum Coccyx SCI	Spine + Back unspecified SCI	Cervical VCI	Thoracic / Dorsal VCI	Lumbar VCI	Sacrum Coccyx VCI	Spine + Back unspecified SCI
Fracture 800-829	806.0-.1	806.2-.3	806.4-.5	806.6-.7	806.8-.9	805.0-.1	805.2-.3	805.4-.5	805.6-.7	805.8-.9
Dislocation 830-839	-	-	-	-	-	839.0-.1	839.21 839.31	839.20 839.30	839.41-.42 839.51-.52	839.40 839.49 839.50 839.59
Sprains & Strains 840-848	-	-	-	-	-	847.0	847.1	847.2	847.3-.4	-
Internal 850-854 860-869 952 995.55	952	952.1	952.2	952.3-.4	952.8-.9	-	-	-	-	-
Open Wound 870-884 890-894	-	-	-	-	-	-	-	-	-	-
Amputations 885-887 895-897	-	-	-	-	-	-	-	-	-	-
Blood Vessels 900-904	-	-	-	-	-	-	-	-	-	-
Contusion / Superficial 910-924	-	-	-	-	-	-	-	-	-	-
Crush 925-929	-	-	-	-	-	-	-	-	-	-
Burns 940-949	-	-	-	-	-	-	-	-	-	-
Nerves 950-951 953-957	-	-	-	-	-	-	-	-	-	-
Unspecified 959	-	-	-	-	-	-	-	-	-	-

Source: http://www.cdc.gov/nchs/data/ice/final_matrix_post_ice.pdf

Table 5: Modification of the Barell Injury Diagnosis Matrix, Classification by Body Region (Torso) and Nature of the Injury

Torso					
	Torso				
	Chest (Thorax)	Abdomen	Pelvis & Urogenital	Trunk	Back and Buttock
Fracture 800-829	807.0-.4	-	808	809	-
Dislocation 830-839	839.61 839.71	-	839.69 839.79	-	-
Sprains & Strains 840-848	848.3-.4	-	846 848.5	-	847.9
Internal 850-854 860-869 952 995.55	860-862	863-866 868	867	-	-
Open Wound 870-884 890-894	875 879.0-.1	879.2-.5	877-878	879.6-.7	876
Amputations 885-887 895-897	-	-	-	-	-
Blood Vessels 900-904	901	902.0-.4	902.5 902(.81-.82)	-	-
Contusion / Superficial 910-924	922.0 922.1 922.33	922.2	922.4	911 922.8-.9	922.31-.32
Crush 925-929	926.19	-	926.0 926.12	926.8-.9	926.11
Burns 940-949	942.x1-.x2	942.x3 947.3	942.x5 947.4	942.x0 942.x9	942.x4
Nerves 950-951 953-957	953.1	953.2 953.5	953.3	954.1 954.8-.9	-
Unspecified 959	-	-	x	959.1	-

Source: http://www.cdc.gov/nchs/data/ice/final_matrix_post_ice.pdf

Table 6: Modification of the Barell Injury Diagnosis Matrix, Classification by Body Region (Extremities) and Nature of the Injury

Extremities										
	Upper				Lower					
	Shoulder & Upper Arm	Forearm & Elbow	Wrist, Hand, & Fingers	Other & Unspecified	Hip	Upper Leg & Thigh	Knee	Lower Leg & Ankle	Foot & Toes	Other & Unspecified
Fracture 800-829	810-812	813	814-817	818	820	821	822	823-824	825-826	827
Dislocation 830-839	831	832	833 834	-	835	-	836	837	838	-
Sprains & Strains 840-848	840	841	842	-	843	-	844.0-.3	845.0	845.1	844.8 844.9
Internal 850-854 860-869 952 995.55	-	-	-	-	-	-	-	-	-	-
Open Wound 870-884 890-894	880	881.x0-.x1	881.x2 882 883	884	X	X	X	X	892-893	890-891 894
Amputations 885-887 895-897	887.2-.3	887.0-.1	885-886	887.4-.7	-	897.2-.3	-	897.0-.1	895-896	897.4-.7
Blood Vessels 900-904	-	-	-	903	-	-	-	-	-	904.0-.8
Contusion / Superficial 910-924	912 923.0	923.1	914-915 923.2-.3	913 923.8 923.9	924 .01	924.00	924.11	924.10 924.21	917 924.3 924.20	916 924.4-.5
Crush 925-929	927.0	927.1	927.2-.3	927.8-.9	928 .01	928.00	928.11	928.10 928.21	928.3 928.20	928.8 928.9
Burns 940-949	943.x3-.x6	943.x1-.x2	944	943.x0 943.x9	-	945.x6	945.x5	945.x3-.x4	945.x1-.x2	945.x0-.x9
Nerves 950-951 953-957	-	-	-	953.4 955	-	-	-	-	-	-
Unspecified 959	959.2	-	959.4-.5	959.3	-	-	-	-	-	959.6-.7

Source: http://www.cdc.gov/nchs/data/ice/final_matrix_post_ice.pdf

Table 7: Modification of the Barell Injury Diagnosis Matrix, Classification by Body Region (Unclassifiable by Site) and Nature of the Injury

	Unclassifiable by Site		
	Other & Unspecified		System Wide
	Other / Multiple	Unspecified Site	System-wide & Late Effects
Fracture 800-829	819 828	829	
Dislocation 830-839	-	823.8-.9	
Sprains & Strains 840-848	-	848.8-.9	
Internal 850-854 860-869 952 995.55	-	869	
Open Wound	-	879.8-.9	
870-884 890-894			930-939 958
Amputations 885-887 895-897	-	-	960-979 980-989 990-994
Blood Vessels 900-904	902.87 902.89	902.9 904.9	995.50-.54 995.59
Contusion / Superficial 910-924	-	919 924.8 924.9	995.80-.85 805-909 909.3
Crush 925-929	-	929	909.5
Burns 940-949	947.1-.2	946 947.8 947.9 948 949	
Nerves 950-951 953-957	953.8 956	953.9 957.1 957.8 957.9	

Unspecified 959	-	959.8 959.9	

Source: http://www.cdc.gov/nchs/data/ice/final_matrix_post_ice.pdf

Appendix 2: Indiana Hospitals

Hospital Name	City / Town	District	Zip	Trauma Center	CAH
ADAMS MEMORIAL HOSPITAL	DECATUR	3	46733		Yes
BLUFFTON REGIONAL MEDICAL CENTER	BLUFFTON	3	46714		
CAMERON MEMORIAL COMMUNITY HOSPITAL	ANGOLA	3	46703		Yes
CLARK MEMORIAL HOSPITAL	JEFFERSONVILLE	9	47130		
COLUMBUS REGIONAL HOSPITAL	COLUMBUS	8	47201		
COMMUNITY HOSPITAL (MUNSTER)	MUNSTER	1	46321		
COMMUNITY HOSPITAL EAST	INDIANAPOLIS	5	46219		
COMMUNITY HOSPITAL NORTH	INDIANAPOLIS	5	46256		
COMMUNITY HOSPITAL OF ANDERSON & MADISON COUNTY	ANDERSON	6	46011		
COMMUNITY HOSPITAL OF BREMEN, IN	BREMEN	2	46506		Yes
COMMUNITY HOSPITAL SOUTH	INDIANAPOLIS	5	46227		
COMMUNITY HOWARD REGIONAL HEALTH SYSTEM	KOKOMO	6	46902		
DAVIESS COMMUNITY HOSPITAL	WASHINGTON	10	47501		
DEACONESS HOSPITAL	EVANSVILLE	10	47747	Yes	
DEARBORN COUNTY HOSPITAL	LAWRENCEBURG	9	47025		
DECATUR COUNTY MEMORIAL HOSPITAL	GREENSBURG	9	47240		Yes
DEKALB HEALTH	AUBURN	3	46706		
DOCTOR'S HOSPITAL	BREMEN	2	46506		
DUKES MEMORIAL HOSPITAL	PERU	3	46970		Yes
DUPONT HOSPITAL	FORT WAYNE	3	46825		
ELKHART GENERAL HOSPITAL	ELKHART	2	46514		
ESKENAZI HEALTH	INDIANAPOLIS	5	46202	Yes	
FAYETTE REGIONAL HEALTH SYSTEM	CONNERSVILLE	6	47331		
FLOYD MEMORIAL HOSPITAL AND HEALTH SERVICES	NEW ALBANY	9	47150		
FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	CROWN POINT	1	46307		
FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CITY	MICHIGAN CITY	1	46360		
FRANCISCAN ST ELISABETH HEALTH - CRAWFORDSVILLE	CRAWFORDSVILLE	4	47933		
FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE CENTRAL	LAFAYETTE	4	47904		
FRANCISCAN ST ELIZABETH HEALTH - LAFAYETTE EAST	LAFAYETTE	4	47905		
FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	INDIANAPOLIS	5	46237		
FRANCISCAN ST FRANCIS HEALTH - MOORESVILLE	MOORESVILLE	5	46158		
FRANCISCAN ST MARGARET HEALTH - DYER	DYER	1	46311		
FRANCISCAN ST MARGARET HEALTH - HAMMOND	HAMMOND	1	46320		
GIBSON GENERAL HOSPITAL	PRINCETON	10	47670		Yes
GOOD SAMARITAN HOSPITAL	VINCENNES	10	47591		
GREENE COUNTY GENERAL HOSPITAL	LINTON	7	47441		Yes
HANCOCK REGIONAL HOSPITAL	GREENFIELD	5	46140		
HARRISON COUNTY HOSPITAL	CORYDON	9	47112		Yes
HENDRICKS REGIONAL HEALTH	DANVILLE	5	46122		
HENRY COUNTY MEMORIAL HOSPITAL	NEW CASTLE	6	47362		
IU HEALTH - ARNETT HOSPITAL	LAFAYETTE	4	47905	Yes	
IU HEALTH - BALL MEMORIAL HOSPITAL	MUNCIE	6	47303	Yes	
IU HEALTH - BEDFORD HOSPITAL	BEDFORD	8	47421		Yes
IU HEALTH - BLACKFORD HOSPITAL	HARTFORD CITY	6	47348		Yes

IU HEALTH - BLOOMINGTON HOSPITAL	BLOOMINGTON	8	47403		
IU HEALTH - GOSHEN HOSPITAL	GOSHEN	2	46526		
IU HEALTH - LA PORTE HOSPITAL	LA PORTE	1	46350		
IU HEALTH - METHODIST HOSPITAL	INDIANAPOLIS	5	46206	Yes	
IU HEALTH - MORGAN HOSPITAL INC	MARTINSVILLE	5	46151		
IU HEALTH - NORTH HOSPITAL	CARMEL	5	46032		
IU HEALTH - PAOLI HOSPITAL	PAOLI	8	47454		Yes
IU HEALTH - RILEY HOSPITAL FOR CHILDREN	INDIANAPOLIS	5	46202	Yes	
IU HEALTH - SAXONY HOSPITAL	FISHERS	5	46037		
IU HEALTH - STARKE HOSPITAL	KNOX	2	46534		
IU HEALTH - TIPTON HOSPITAL INC	TIPTON	6	46072		Yes
IU HEALTH - WEST HOSPITAL	AVON	5	46123		
IU HEALTH - WHITE MEMORIAL HOSPITAL	MONTICELLO	4	47960		Yes
JASPER MEMORIAL HOSPITAL	RENSSELAER	1	47978		Yes
JAY COUNTY HOSPITAL	PORTLAND	6	47371		Yes
JOHNSON MEMORIAL HOSPITAL	FRANKLIN	5	46131		
KING'S DAUGHTERS' HOSPITAL AND HEALTH SERVICES	MADISON	9	47250		
KOSCIUSKO COMMUNITY HOSPITAL	WARSAW	2	46580		
LUTHERAN HOSPITAL OF INDIANA	FORT WAYNE	3	46804	Yes	
MAJOR HOSPITAL	SHELBYVILLE	5	46176		
MARGARET MARY COMMUNITY HOSPITAL INC	BATESVILLE	9	47006		Yes
MARION GENERAL HOSPITAL	MARION	6	46952		
MEMORIAL HOSPITAL & HEALTH CARE CENTER	JASPER	10	47546		
MEMORIAL HOSPITAL LOGANSPORT	LOGANSPORT	4	46947		
MEMORIAL HOSPITAL OF SOUTH BEND	SOUTH BEND	2	46601	Yes	
METHODIST HOSPITALS INC NORTHLAKE CAMPUS	GARY	1	46402		
METHODIST HOSPITALS INC SOUTHLAKE CAMPUS	MERRILLVILLE	1	46410		
MONROE HOSPITAL	BLOOMINGTON	8	47403		
PARKVIEW HUNTINGTON HOSPITAL	HUNTINGTON	3	46750		
PARKVIEW LAGRANGE HOSPITAL	LAGRANGE	3	46761		Yes
PARKVIEW NOBLE HOSPITAL	KENDALLVILLE	3	46755		
PARKVIEW RANDALLIA HOSPITAL	FORT WAYNE	3	46805		
PARKVIEW REGIONAL MEDICAL CENTER	FORT WAYNE	3	46805	Yes	
PARKVIEW WHITLEY HOSPITAL	COLUMBIA CITY	3	46725		
PERRY COUNTY MEMORIAL HOSPITAL	TELL CITY	10	47586		Yes
PEYTON MANNING CHILDREN'S HOSPITAL AT ST. VINCENT	INDIANAPOLIS	5	46260		
PORTER - PORTAGE HOSPITAL	PORTAGE	1	46368		
PORTER - VALPARAISO HOSPITAL	VALPARAISO	1	46383		
PULASKI MEMORIAL HOSPITAL	WINAMAC	2	46996		Yes
PUTNAM COUNTY HOSPITAL	GREENCASTLE	7	46135		Yes
REID HOSPITAL & HEALTH CARE SERVICES	RICHMOND	6	47374		
RICHARD L ROUDEBUSH VA MEDICAL CENTER	INDIANAPOLIS	5	46202		
RIVERVIEW HOSPITAL	NOBLESVILLE	5	46060		
RUSH MEMORIAL HOSPITAL	RUSHVILLE	6	46713		Yes
SAINT CATHERINE REGIONAL HOSPITAL	CHARLESTOWN	9	47111		
SCHNECK MEDICAL CENTER	SEYMOUR	8	47274		
SCOTT COUNTY MEMORIAL HOSPITAL	SCOTTSBURG	9	47170		Yes

ST CATHERINE HOSPITAL INC	EAST CHICAGO	1	46312		
ST JOHN'S HEALTH SYSTEM	ANDERSON	6	46016		
ST JOSEPH HOSPITAL	FORT WAYNE	3	46802		
ST JOSEPH HOSPITAL & HEALTH CENTER (KOKOMO)	KOKOMO	6	46904		
ST JOSEPH REGIONAL MEDICAL CENTER MISHAWAKA	MISHAWAKA	2	46544		
ST JOSEPH REGIONAL MEDICAL CENTER PLYMOUTH	PLYMOUTH	2	46563		
ST MARY MEDICAL CENTER HOBART	HOBART	1	46342		
ST MARY'S MEDICAL CENTER OF EVANSVILLE	EVANSVILLE	10	47750	Yes	
ST MARY'S WARRICK HOSPITAL	BOONVILLE	10	47601		Yes
ST VINCENT ANDERSON REGIONAL HOSPITAL	ANDERSON	6	46016		
ST VINCENT CARMEL HOSPITAL	CARMEL	5	46032		
ST VINCENT CLAY HOSPITAL	BRAZIL	7	47834		Yes
ST VINCENT DUNN HOSPITAL INC	BEDFORD	8	47421		Yes
ST VINCENT FRANKFORT HOSPITAL	FRANKFORT	4	46041		Yes
ST VINCENT HOSPITAL - INDIANAPOLIS	INDIANAPOLIS	5	46260	Yes	
ST VINCENT JENNINGS HOSPITAL	NORTH VERNON	9	47265		Yes
ST VINCENT MEDICAL CENTER NORTHEAST	FISHERS	5	46037		
ST VINCENT MERCY HOSPITAL, INC	ELWOOD	6	46036		Yes
ST VINCENT RANDOLPH HOSPITAL	WINCHESTER	6	47394		Yes
ST VINCENT SALEM HOSPITAL	SALEM	8	47167		Yes
ST VINCENT WILLIAMSPORT HOSPITAL	WILLIAMSPORT	4	47993		Yes
SULLIVAN COUNTY COMMUNITY HOSPIT	SULLIVAN	7	47882		Yes
TERRE HAUTE REGIONAL HOSPITAL	TERRE HAUTE	7	47802		
THE HEART HOSPITAL AT DEACONESS GATEWAY LLC	NEWBURGH	10	47630		
UNION HOSPITAL CLINTON	CLINTON	7	47842		
UNION HOSPITAL, INC	TERRE HAUTE	7	47804		Yes
WABASH COUNTY HOSPITAL	WABASH	3	46992		Yes
WESTVIEW HOSPITAL	INDIANAPOLIS	5	46222		
WITHAM HEALTH SERVICES	LEBANON	5	46052		
WOODLAWN HOSPITAL	ROCHESTER	2	46975		Yes

Appendix 3: Glossary of Terms

Appendix 3: Glossary of Terms

Based on the 2015 NTDB Data Dictionary "Glossary of Terms"

Co-Morbid Conditions

Co-Morbid Condition	ICD-9 Code Range	ICD-10 Code Range
***Advanced directive limiting care:** The patient had a Do Not Resuscitate (DNR) document or similar advanced directive recorded prior to injury.		Z66 (Do not resuscitate)
Alcoholism: Evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in absence of history of abuse.	291.0 -291.3 291.81 291.9 303.90-303.93 V11.3	F10.220-F10.229 (Alcohol dependence wit h intoxication) F10.230-F10.239 (Alcohol dependence with withdrawal) F10.26 (Alcohol dependence with amnestic disorder) F10.27 (Alcohol dependence with persisting dementia) F10.280-F10.288 (Alcohol dependence with other alcohol induced disorders) F10.29 (Alcohol dependence with NOS alcohol induced disorders) F10.20-F10.21 (Alcohol dependence, in remission – Formerly V11.3)
Ascites within 30 days: The presence of fluid accumulation (other than blood) in the peritoneal cavity noted on physical examination, abdominal ultrasound, or abdominal CT/MRI.	789.51 789.59	R18.0 R18.8
***Attention deficit disorder/ Attention deficit hyperactivity disorder (ADD/ ADHD):** History of a disorder involving inattention, hyperactivity or impulsivity requiring medication for treatment.	314.01	
Bleeding disorder: Any condition that places the patient at risk for excessive bleeding due to a deficiency of blood clotting elements (e.g., vitamin K deficiency, hemophilia, thrombocytopenia, chronic anticoagulation therapy with Coumadin, Plavix, or similar	286.0-286.9 287.1-287.49 V58.61 V58.63	D66 (Hereditary factor VII) D67 (Hereditary factor XI) D68.0 (Von Willebrand's Disease) D68.1 (Hereditary factor XI) D68.2 (Hereditary deficiency of other clotting factors) D68.31-D68.32 (Hemorrhagic disorder (intrinsic, extrinsic)) D68.4 (Acquired coagulation

medications). Do not include patients on chronic aspirin therapy.		factor deficiency) D69.1 (Qualitative platelet defects) D69.2 (Other nonthrombocytopenic purpura) D69.3 (Immune thrombocytopenic purpura) D69.41-D69.49 (Other primary thrombocytopenia) D69.51-D69.59 (Secondary thrombocytopenia) Z79.01 (Long term (current) use of anticoagulants) Z79.02 (Long term (current) use of antithrombotics/antiplatelets)
Currently receiving chemotherapy for cancer: A patient who is currently receiving any chemotherapy treatment for cancer prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.		Z51.11 (Encounter for antineoplastic chemotherapy)
Congenital Anomalies: Defined as documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopaedic, or metabolic congenital anomaly.	740.0 - 759.89	Q000.0 – Q99.9
Congestive heart failure: Defined as the inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset or increasing symptoms within 30 days prior to injury. Common manifestations are:	398.91 428.0 - 428.9 402.01 402.11 402.91 404.11 404.13 404.91 425.0 - 425.4	I09.81 (Rheumatic heart failure) I50.1-I50.9 (Heart Failure) I11.0 (Hypertensive disease with heart failure) I13.0 (Hypertensive disease with CKD 1 - 4with heart failure) I13.2 (Hypertensive disease with CKD 5 with heart failure) I42.0 (Dilated cardiomyopathy) I42.1 (Obstructive hypertrophic cardiomyopathy) I42.2 (Other hypertrophic cardiomyopathy) I42.3 (Endomyocardial (eosinophilic) disease)

Abnormal limitation in exercise tolerance due to dyspnea or fatigue Orthopnea (dyspnea on lying supine) Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea) Increased jugular venous pressure Pulmonary rales on physical examination Cardiomegaly Pulmonary vascular engorgement		I42.4 (Endocardial fibroelastosis) I42.5 (Other restrictive cardiomyopathy) I42.8
Current smoker: A patient who reports smoking cigarettes every day or some days. This excludes patients who smoke cigars or pipes or use smokeless tobacco (chewing tobacco or snuff).		F17.210 (Nicotine dependence, cigarettes, uncomplicated) F17.213 (Nicotine dependence, cigarettes, with withdrawal) F17.218-F17.219 (Nicotine dependence, cigarettes, other/NOS nicotine-induced disorders)
Chronic renal failure: Acute or chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.	403.01 403.11 403.91 404.02 404.12 404.03 404.13 404.92 404.93	I12.0 (Hypertensive CKD – Stage 5) I13.11 (Hypertensive heart and CKD – Stage 5 without heart failure) I13.2 (Hypertensive heart and CKD – Stage 5 with heart failure) N18.5 (CKD – Stage 5) N18.6 (End stage renal disease)
CVA/residual neurological deficit: A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory, or cognitive dysfunction. (E.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).	434.01 434.11 434.91 433.01-433.91 438.0-438.9	I63.30–I63.39 (Cerebral infarction – thrombosis of cerebral artery) I64.40–I64.49 (Cerebral infarction – embolism of cerebral artery) I64.50–I64.59 (Cerebral infarction – occlusion or stenosis of cerebral artery) I63.00–I63.09 (Cerebral infarction – thrombosis of precerebral artery) I63.10–I63.19 (Cerebral infarction – embolism of precerebral artery) I63.20–I63.29 (Cerebral infarction – occlusion or stenosis of

		precerebral artery) I63.6 (Cerebral infarction – cerebral venous thrombosis, nonpyogenic) I69.30-I69.398 (Sequelae of cerebral infarction)
Diabetes mellitus: Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent.	250.00-250.93	E08.00-E13.9 (Diabetes mellitus)
Disseminated cancer: Patients who have cancer that: Has spread to one site or more sites in addition to the primary site AND In whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Other terms describing disseminated cancer include "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, bone).	196.0-199.1	C7B.00-C7B.8 (Secondary neuroendocrine tumors) C77.0-C77.9 (Secondary malignant neoplasms of lymph nodes) C78.00-C78.89 (Secondary malignant neoplasms of respiratory and digestive organs) C79.00-C79.9 (Secondary malignant neoplasms of other and unspecified sites) C80.0 (Disseminated malignant neoplasm NOS)
Esophageal varices: Esophageal varices are engorged collateral veins in the esophagus which bypass a scarred liver to carry portal blood to the superior vena cava. A sustained increase in portal pressure results in esophageal varices which are most frequently demonstrated by direct visualization at esophagoscopy.	456.0-456.21	I85.00-I85.11 (Esophageal varices)
Functionally dependent health status: Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, prior to injury, was partially		

dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living. Formal definitions of dependency are listed below: Partially dependent: The patient requires the use of equipment or devices coupled with assistance from another person for some activities of daily living. Any patient coming from a nursing home setting who is not totally dependent would fall into this category, as would any patient who requires kidney dialysis or home ventilator support that requires chronic oxygen therapy yet maintains some independent functions. Totally dependent: The patient cannot perform any activities of daily living for himself/herself. This would include a patient who is totally dependent upon nursing care, or a dependent nursing home patient. All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient.		
History of angina within past 1 month: Pain or discomfort between the diaphragm and the mandible resulting from myocardial ischemia. Typically angina is a dull, diffuse (fist sized or larger) substernal chest discomfort precipitated by exertion or emotion and relieved by rest or nitroglycerine. Radiation often occurs to the arms and shoulders and occasionally to the neck, jaw (mandible, not maxilla), or interscapular region. For patients on anti-anginal medications, enter yes only if the patient has had angina within one month prior to admission.	413.0-413.9	I20.0-I20.9 (Angina pectoris)
History of myocardial	410.00	I21.01-I21.29 (STEMI myocardial

infarction: The history of a non-Q wave, or a Q wave infarction in the six months prior to injury as diagnosed in the patient's medical record.	410.01 410.10 410.11 410.20 410.21 410.30 410.31 410.40 410.41 410.50 410.51 410.60 410.61 410.70 410.71 410.80 410.81 410.90 410.91	infarction) I21.4 (Non-STEMI myocardial infarction) I22.0-I22.9 (Subsequent (recurrent) myocardial infarction) I23.0-I23.9 (Certain current complications following myocardial infarction) I25.2 Z86.74 (Personal history of sudden cardiac arrest)
Hypertension requiring medication: History of a persistent elevation of systolic blood pressure >140 mm Hg and a diastolic blood pressure >90 mm Hg requiring an antihypertensive treatment (e.g., diuretics, beta blockers, angiotensin-converting enzyme (ACE) inhibitors, calcium channel blockers).	401.0 401.1 401.9 642.00-642.04 642.20-642.24 642.30-642.34 402.0-402.91 403.00-403.91 404.00-404.93 405.01-405.99	I10 (Essential Hypertension) I11.0-I11.9 (Hypertensive heart disease) I13.0-I13.11 (Hypertensive heart and CKD) I15.0-I15.9 (Secondary hypertension)
Prematurity: Defined as documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth.- Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.	765.00-765.19 765.20-765.29 770.7	P07.20-P07.23(Extreme immaturity of newborn) P07.30-P07.32 (Other preterm newborn) P27.1 (Bronchopulmonary dysplasia originating in the prenatal period)
Obesity: Defined as a Body Mass Index of 30 or greater.	278.00-278.01 V85.3-V85.4	(Note E66.3 – Overweight excluded) E66.01-E66.2 (Obesity from specified cause) E66.8-E66.9 (Other and NOS obesity) Z68.30-Z68.45 (BMIs 30 or greater in adults) Z68.53-Z68.54 (BMI 85 percentile or greater – pediatric)
Respiratory Disease: Defined as severe chronic lung disease, chronic asthma, cystic fibrosis, or chronic obstructive pulmonary	011.00-011.66 011.8-011.99 012.0-012.9 277.02	A15.0-A15.9 (Respiratory Tuberculosis) E84.0 (Cystic Fibrosis with pulmonary manifestations)

disease (COPD) such as emphysema and/or chronic bronchitis resulting in any one or more of the following: Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]) Hospitalization in the past for treatment of COPD Requires chronic bronchodilator therapy with oral or inhaled agents A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing Do not include patients whose only pulmonary disease is acute asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.	491.0-491.9 492.0-492.8 493.00-493.92 494.0-494.1 495.0-495.9 496 518.2 518.83-518.89	J41.0-J41.8 (Simple and mucopurulent chronic bronchitis) J42 (NOS chronic bronchitis) J43.0-J43.9 (Emphysema) J44.0-J44.9 (COPD) J47.0-J47.9 (Bronchiectasis) J96.10-J96.12 (Chronic respiratory failure) J96.20-J96.22 (Acute and chronic respiratory failure) J98.3 (Compensatory emphysema)
Steroid use: Patients that required the regular administration of oral or parenteral corticosteroid medications (e.g., prednisone, dexamethasone in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.	V58.65	Z79.51-Z79.52 (Long term current drug therapy – steroids)
Cirrhosis: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then	571.2 571.5 571.6 571.8 571.9 572.2 572.3 572.4 572.8	K70.30-K70.31 (Alcoholic cirrhosis of the liver) K72.00-K72.91 (Hepatic failure) K74.3-K74.5 (Biliary cirrhosis) K74.60 (NOS cirrhosis of liver) K74.69 (Other cirrhosis of liver) K76.6 (Portal hypertension) K76.7 (Hepatorenal syndrome)

cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.		
Dementia: With particular attention to senile or vascular dementia (eg Alzheimer's).	290.0-290.43 294.0-294.11 331.0-331.2 331.82-331.89 332.0-332.1 333.0 333.4	F01.50-F01.51 (Vascular dementia) F02.80-F02.81 (Dementia in other diseases classified elsewhere) F03 (NOS dementia) F04 (Amnestic disorder) G30.0-G30.9 (Alzheimer's disease) G31.01-G31.09 (Pick's disease & other frontotemporal dementia) G31.1 (Senile degeneration of brain) G31.82 (Dementia with Lewy bodies) G31.84 (Mild cognitive impairment) G31.89 (Other specified degenerative diseases of the nervous system G20 (Primary Parkinson's disease) G21.0-G21.9 (Secondary Parkinson's disease) G23.0-G23.9 (Other degenerative diseases of the basal ganglia) G10 (Huntington's disease)
Major psychiatric illness: Defined as documentation of the presence of pre-injury major depressive disorder, bipolar disorder, schizophrenia, anxiety / panic disorder, borderline or antisocial personality disorder, and / or adjustment disorder / post-traumatic stress disorder.	295.00-297.9 300.0-300.09 301.0-301.7 301.83 309.81 311 V11.0-V11.2 V11.4-V11.8	F20.0-F29 (Schizophrenia and non-mood psychotic disorders) F30.0-F39 (Mood [affective] disorders) F44.0-F44.9 (Dissociative and conversion disorders) F60.0 (Paranoid personality disorder) F60.1 (Schizoid personality disorder) F60.2 (Anti-social personality disorder) F60.3 (Borderline personality disorder) F60.4 (histrionic personality disorder) F60.5 (Obsessive-compulsive disorder) F60.7 (Dependent personality disorder) F43.10-F43.12 (PTSD)

		Z86.51 (PH of combat and operational stress reaction) Z86.59 (PH of other mental and behavioral disorders)
Drug use disorder: If a patient has a history documented in their medical record, they would qualify for this. If patient tests positive for an illegal drug or a legal drug that was taken illegally, they would qualify for this as well.	304.00-304.8 305.2-305.9	F11.10-F11.99 (Opioid related disorders) F12.10-F12.99 (Cannabis related disorders) F13.10-F13.99 (Sedative, hypnotic, or anxiolytic related disorders) F14.10-F14.99 (Cocaine disorders) F15.10-F15.99 (Other stimulant related disorders) F16.10-F16.99 (Other hallucinogen related disorder) F18.10-F18.99 (Inhalant related disorders) F19.10-F19.99 (Other psychoactive substance related disorder)
Pre-hospital cardiac arrest with CPR: A sudden, abrupt loss of cardiac function which occurs outside of the hospital, prior to admission at the center in which the registry is maintained, that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support by a health care provider.		

Hospital Complications

Hospital Complications	ICD-9 Code Range	ICD-10 Code Range
Acute kidney injury: Acute kidney injury, AKI(stage 3) Is an abrupt (within 48 hours) Reduction of kidney function Defined as: Increase in serum Creatinine (SCr) of more than or Equal to 3x baseline or; Increase in SCr to greater than or equal to 4mg/dl (greater than or equal to 353.3umol/l) or; Patients greater than 18 years with a decrease in eGFR to less than or equal to 35 ml/min per 1.73 m (squared) or; reduction in urine output of Less than 0.3 ml/kg/hr for greater than or equal to 24 hrs or; anuria for greater than or less than 12 hrs or; requiring renal replacement therapy (e.g. continuous renal therapy (CRRT) or periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration). NOTE: If the patient or family refuses treatment (e.g. dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present. EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.	584.5-584.9 588.0-588.9 585.1 585.89 585.9 593.9 958.5	N17.0-N17.9 (Acute kidney failure) N25.0 (Renal osteodystrophy) N25.1 (Nephrogenic diabetes insipidus) N25.89 (Other disorders result from impaired renal tubular function) N25.9 (Disorders results from impaired renal tubular function NOS) N18.1 (CKD Stage 1) N18.9 (CKD NOS) N28.9 (Disorder of kidney and ureter NOS) T79.5xxA (Traumatic anuria – initial)
ALI/ARDS: Acute Lung Injury/Adult (Acute) Respiratory Distress Syndrome: ALI/ARDS occurs in conjunction with catastrophic medical conditions, such as pneumonia, shock, sepsis (or severe infection throughout the body, sometimes also referred to as systemic infection, and may include or also be called a blood or blood-borne infection), and trauma. Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms. Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules Origin of edema: Respiratory failure not full explained by cardiac failure of fluid overload. Need objective assessment (e.g., echocardiography) to exclude hybrostatic edema if no risk factor present Oxygenation (at a minimum): 200<Pa02/Fi02 <_ 300 with PEEP or CPAP _>5 cmH20c	518.5 518.82	J95.1-J95.3 (Acute and chronic pulmonary insufficiency after surgery) J95.82-J95.822 J95.89 (Other postprocedural complication & disorder of respiratory system NEC)

Cardiac arrest with CPR: Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of Circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. INCLUDE patients who have had an episode of cardiac arrest	427.5 in conjunction with 99.60-99.69 427.5 with 37.91 V12.53	I46.2-I46.9 (Cardiac arrest) with PCS Codes of: 5A12012 (Performance of Cardiac Output, Single, Manual) 5A2204Z (Restoration of Cardiac Rhythm) 02QA0ZZ (Repair of Heart, Open
evaluated by hospital personnel and Received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.		Approach) 02QC0ZZ (Repair of Left Heart, Open Approach) 02QB0ZZ (Repair of Right Heart, Open Approach)
Decubitus ulcer: Defined as any partial or full thickness loss of dermis resulting from pressure exerted by the patient's weight against a surface. Deeper tissues may or may not be involved. Equivalent to NPUAP Stages II – IV and NPUAP "unstageable" ulcers. EXCLUDES intact skin with nonblanching redness (NPUAP Stage I), which is considered reversible tissue injury.	707.00-707.09 with one code from 707.22-707.25 to indicate the stage using the highest stage documented	L89.000-L89.95 (Pressure ulcer) with at least one code in the range with a sixth digit ending in 2, 3, or 4 – Stage II, III, IV, e.g. L89.303 – Pressure ulcer of buttock, stage 3)
Deep surgical site infection: Defined as a deep incisional SSI must meet one of the following criteria: Infection occurs within 30 days after the operative procedure if no implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision AND patient has at least one of the following:	674.30 674.32 674.34 996.60-996.63 996.66-996.69 998.59	O86.0 (Infection of obstetric surgical wound) O90.2 (Hematoma of obstetric wound) T81.4xxA (Infection after a procedure – initial) T82.6xxA (Infection and Inflammatory reaction – cardiac valve – initial) T82.7xxA (Infection and inflammatory other CV devices/implants/grafts – initial) T84.50xA (Infection/inflammation – NOS internal joint prosthesis – initial) T84.60xA (Infection/inflammation – internal fixation device of NOS site – initial)

purulent drainage from the deep incision but not from the organ/space component of the surgical site of the following: a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured when the patient has at least one of the following signs or symptoms: fever (>38°C), or localized pain or tenderness. A culture-negative finding does not meet this criterion. an abscess or other evidence of		T84.7xxA (Infection/inflammation other orthopedic prosthetic devices/implants/grafts – initial) T85.71xA (Infection and inflammatory reaction – peritoneal dialysis catheter – initial) T85.79xA (Infection and inflammatory reaction – other internal prosthetics/implants/grafts – initial) K68.11 (Postprocedural retroperitoneal abscess)

infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination diagnosis of a deep incisional SSI by a surgeon or attending physician. NOTE: There are two specific types of deep incisional SSIs: Deep Incisional Primary (DIP)- a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB) Deep Incisional Secondary (DIS)- a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CBGB) REPORTING INSTRUCTIONS: Classify infection that involves both superficial and deep incision sites as deep incisional SSI.		
Drug or alcohol withdrawal syndrome: Defined as a set of symptoms that may occur when a person who has been habitually drinking too much alcohol or habitually using certain drugs (e.g. narcotics, benzodiazepine) experiences physical symptoms upon suddenly stopping consumption. Symptoms may include: activation syndrome (i.e., tremulousness, agitation, rapid heartbeat and high blood pressure), seizures, hallucinations or delirium tremens.	291.0 291.3 291.81 292.0	F10.230-F10.239 (Alcohol dependence with withdrawal) F11.23 (Opioid dependence with withdrawal) F13.230-F13.239 (Sedative dependence with withdrawal) F14.23 (Cocaine dependence with withdrawal) F15.23 (Other stimulant dependence with withdrawal) F19.230-F19.239 (Other psychoactive substance dependence with withdrawal)
Deep Vein Thrombosis (DVT): The formation, development, or existence of a blood clot or	451.0 451.11 451.19	I81.10-I80.13 (phlebitis and thrombophlebitis of femoral vein) I81.201-I81.299 (Phlebitis and

thrombus within the vascular system, which may be coupled with inflammation. This diagnosis may be confirmed by a venogram, ultrasound, or CT. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.	451.2 451.81- 451.84 451.89 451.9 453.40 459.10-459.19 997.2 999.2	thrombophlebitis of other and unspecified veins of lower extremity) I80.3 (Phlebitis and thrombophlebitis of lower extremity NOS) I80.8 (Phlebitis and thrombophlebitis of other site) I80.9 (Phlebitis and thrombophlebitis of NOS site) I87.001-I87.099 (Post-thrombotic syndrome) T80.1xxA (Vascular complication infusion/transfusion/therapeutic injection – initial) I82.4-I82.429 T81.72xA (Complication of vein after procedure NEC – initial)
Extremity compartment syndrome: Defined as a condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure) requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.	729.71 729.72 998.89 958.91 958.92 958.90	M79.A11-M79.A19 (Nontraumatic compartment syndrome of UE) M79.A21-M79.A29 (Nontraumatic compartment syndrome of LE) T79.A11A (Traumatic compartment syndrome of right UE initial) T79.A12A (Traumatic compartment syndrome of left UE initial) T79.A19A (Traumatic compartment syndrome of NOS UE initial) T79.A21A (Traumatic compartment of right LE initial) T79.A22A (Traumatic compartment syndrome of left LE initial) T79.A29A (Traumatic compartment syndrome of NOS LE initial)
Graft/prosthesis/flap failure: Mechanical failure of an extracardiac vascular graft or prosthesis including myocutaneous flaps and skin grafts requiring return to the operating room or a balloon angioplasty.	996.00 996.1 996.52 996.55 996.61 996.62 996.72	(initial codes only – ending with 7 character designation of A) T82.010A (Breakdown of heart valve prosthesis – initial) T82.110x-T82.119x (Breakdown of cardiac electronic devices and implants) T82.211A (Breakdown of coronary artery bypass graft) T82.310x-T82.319x (Breakdown of vascular grafts) T82.41xA (Breakdown of vascular dialysis catheter)

		T82.510x-T82.519x (Breakdown of cardiac and vascular devices and implants) T83.010A (Breakdown of cystostomy catheter – initial) T83.080A (Breakdown of other indwelling urethral catheter – initial) T83.110x-T83.118x (Breakdown of other urinary catheter) T83.21xA (Breakdown of graft of urinary organ – initial) T83.410A (Breakdown of penile device/implant/graft – genitalia – initial) T83.418A (Breakdown of other prosthetic device/implant/graft – genitalia – initial) T84.010A (Broken internal R hip prosthesis – initial) T84.011A (Broken internal L hip prosthesis – initial) T84.012A (Broken internal R knee prosthesis – initial) T84.013A (Broken internal L knee prosthesis – initial) T84.018A (Broken internal joint prosthesis other site – initial) T84.110x-T84.119x (Breakdown of internal fixation device for long bones) T84.210x-T84.218x (Breakdown of internal fixation device for bones of foot/hand, vertebrae, and other bones NEC) T84.310A (Breakdown of electronic bone stimulator – initial) T84.318A (Breakdown of other bone device, implants, grafts – initial) T85.01xA (Breakdown of ventricular intracranial shunt – initial) T85.110x-T85.118x (Breakdown of implanted electronic stimulator of nervous system) T85.21xA (Breakdown of intraocular lens – initial) T85.310x-T85.318x (Breakdown of ocular prosthetic device) T85.41xA (Breakdown of GI prosthesis – initial) T85.510x-T85.518x (Breakdown

		of GI prosthesis device) T85.610x-T85.618x (Breakdown of other specified internal prosthesis device)
Myocardial infarction: A new acute myocardial infarction occurring during hospitalization (within 30 days of injury).	414.8 412	I21.01-I21.29 (STEMI myocardial infarction) I21.4 (Non-STEMI myocardial infarction) I22.0-I22.9 (Subsequent (recurrent) myocardial infarction) Excludes: I25.2 (Old myocardial infarction)
Organ/space surgical site infection: Defined as an infection that occurs within 30 days after an operation and infection involves any part of the anatomy (e.g., organs or spaces) other than the incision, which was opened or manipulated during a procedure; and at least one of the following, including: Purulent drainage from a drain that is placed through a stab wound or puncture into the organ/space; Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space; An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination; or Diagnosis of an organ/space SSI by a surgeon or attending physician.	998.59	T81.4xxA (Infection after a procedure – initial) K68.11 (Postprocedural retroperitoneal abscess)
Pneumonia: Patients with evidence of pneumonia that develops during the hospitalization. Patients with pneumonia must meet at least one of the following two criteria: Criterion 1. Rales or dullness to percussion on physical examination of chest AND any of the following:	480.0-480.9 481 482.0-482.3 482.30-483.39 482.40-482.49 482.81-48.89 482.9 483.0-483.8 484.1-484.8 485 486	J14 (Pneumonia – Hemophilus influenza) J15.0-J15.29 (Pneumonia – staphylococcus) J15.3 (Pneumonia – streptococcus B) J15.4 (Pneumonia – other streptococci) J15.5 (Pneumonia – E Coli) J15.7 (Pneumonia – Other aerobic Gram negative bacterial)

New onset of purulent sputum or change in character of sputum Organism isolated from blood culture Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy Criterion 2. Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion AND any of the following: New onset of purulent sputum or change in character of sputum Organism isolated from the blood Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy Isolation of virus or detection of viral antigen in respiratory secretions Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen Histopathologic evidence of pneumonia	997.31	J15.8 (Pneumonia – Mycoplasma pneumonia) J15.9 (Pneumonia – Other bacterial) J16.0-J16.8 (Other infectious pneumonia) J17 (Pneumonia in diseases classified elsewhere) J18.0-J18.9 (Pneumonia, unspecified organism) J95.851
Pulmonary embolism: Defined as a lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram.	415.11 415.12 415.19 416.2	I26.01-I26.99 (Pulmonary embolism) I27.82 (Chronic pulmonary embolism)
Stroke/CVA: A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms: Change in level of consciousness	434.01 434.11 434.91 433.01-433.91 997.02	I63.00-I63.9 (Cerebral Infarction) I65.01-I65.9 (Occlusion and stenosis of vertebral and carotid arteries in the head) I97.810-I97.821 (Intrapoerative and postprocedural CVA)

Hemiplegia Hemiparesis Numbness or sensory loss affecting one side of the body Dysphasia or aphasia Hemianopia Amaurosis fugax Or other neurological signs or symptoms consistent with stroke AND Duration of neurological deficit ≥24 h OR Duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death AND No other readily identifiable nonstroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified AND Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission). Although the neurologic deficit		

must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.		
Superficial surgical site infection: Defined as an infection that occurs within 30 days after an operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following: Purulent drainage, with or without laboratory confirmation, from the superficial incision. Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat and superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. Diagnosis of superficial incisional surgical site infection by the surgeon or attending physician. Do not report the following conditions as superficial surgical site infection: Stitch abscess (minimal inflammation and discharge confined to the points of suture penetration). Infected burn wound. Incisional SSI that extends into the fascial and muscle layers (see deep surgical site infection).	998.59	K68.11 (Postprocedural retroperitoneal abscess) T81.4xxA
Unplanned intubation: Patient requires placement of an endotracheal tube and mechanical or assisted		

ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.		
Urinary Tract Infection: Defined as an infection anywhere along the urinary tract with clinical evidence of infection, which includes at least one of the following symptoms with no other recognized cause: Fever≥38 C WBC> 100,000 or < 3000 per cubicmillimeter Urgency Frequency Dysuria Suprapubictenderness AND positive urine culture (≥100,000 microorganisms per cm^3 of urine with no more than two species of microorganisms) OR at least <u>two</u> of the following signs or symptoms with no other recognized cause: Fever≥38 C WBC> 100,000 or < 3000 per cubicmillimeter Urgency Frequency	595.0-595.9 or 599.0	N30.00-N30.91(Cystitis) N39.0 (Urinary Tract Infection, site not specified)

Dysuria Suprapubic tenderness AND at least <u>one</u> of the following: Positive dipstick for leukocyte esterase and/or nitrate Pyuria (urine specimen with >10 WBC/mm^3 or >3 WBC/high power field of unspun urine) Organisms seen on Gram stain of unspun urine At least two urine cultures with repeated isolation of the same uropathogen (gram-negative bacteria or S. saprophyticus) with ≥102 colonies/ml in nonvoided specimens ≤105 colonies/ml of a single uropathogen (gram-negative bacteria or S. saprophyticus) in a patient being treated with an effective antimicrobial agent for a urinary tract infection Physician diagnosis of a urinary tract infection Physician institutes appropriate therapy for a urinary tract infection Excludes asymptomatic bacteriuria and "other" UTIs that are more like deep space infections of the urinary tract.		
Catheter-Related Blood Stream Infection: Defined as organism cultured from the bloodstream that is not related to an infection at another site but is attributed to a central venous catheter. Patients must have evidence of infection including at least one of: Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures	993.1 790.7 038.0 038.1 038.10 038.11 038.19 038.3 038.4-038.43 038.49 038.8 038.9	R78.81 (Bacteremia) A40.0 (Streptococcal sepsis, group A) A40.1 (Streptococcal sepsis, group B) A40.8 (Other streptococcal sepsis) A40.9 (Streptococcal sepsis, unspecified) A41.01 (Sepsis due to Methicillin susceptible staphylococcus aureus) A41.02 (Sepsis due to Methicillin

and organism cultured from blood is not related to an infection at another site. Criterion 2: Patient has at least one of the following signs or symptoms: Fever>38 C Chills WBC> 100,000 or < 3000 per cubicmillimeter Hypotension (SBP<90) or >25% drop in systolic blood pressure Signs and symptoms and positive laboratory results are not related to an infection at another site AND Common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions. Criterion 3: Patient < 1 year of age has at least one of the following signs or symptoms: Fever (>38°C core) Hypothermia (<36°C core), Apnea, or bradycardia Signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions. Erythema at the entry site of the central line or positive cultures on		resistant staphylococcus aureus) A41.1 (Sepsis due to other specified staphylococcus) A41.2 (Sepsis due to unspecified staphylococcus) A41.4 (Sepsis due to anaerobes) A41.50-A41.59 (Gram-negative sepsis) A41.81-A41.89 (Other specified sepsis) A41.9 (Sepsis, unspecified organism)

the tip of the line in the absence of positive blood cultures is not considered a CRBSI		
Osteomyelitis: Defined as meeting at least one of the following criteria: Organisms cultured from bone. Evidence of osteomyelitis on direct examination of the bone during a surgical operation or histopathologicexamination. At least two of the following signs or symptoms with no other recognized cause: fever (38° C), localized swelling, tenderness, heat, or drainage at suspected site of bone infection and at least one of the following: Organisms cultured from blood Positive blood antigen test (e.g., H. influenzae, S. pneumoniae) Radiographic evidence of infection, e.g., abnormal findings on x-ray, CT scan, magnetic resonance imaging (MRI), radiolabel scan (gallium, technetium, etc.).	730.00-730.29	M86.00M86.9 (Osteomyelitis)
Unplanned return to the OR: Unplanned return to the operating room after initial operation management for a similar or related previous procedure.		
Unplanned return to the ICU: Unplanned return to the intensive care unit after initial ICU discharge. Does not apply if ICU care is required for postoperative care of a planned surgical procedure.		
Severe sepsis: Sepsis and/or Severe Sepsis: Defined as an obvious source of infection with bacteremia and two or more of the following: Temp > 38° C or < 36° C White Blood Cell count > 12,000/mm³, or >20% immature (Source of Infection)	785.52 995.92	R65.20-R65.21 (Severe Sepsis

Hypotension – (Severe Sepsis) Evidence of hypoperfusion: (Severe Sepsis) Anion gap or lactic acidosis or Oliguria, or Altered mental status		

Other Terms

Patient's Occupational Industry: The occupational history associated with the patient's work environment.

Field Value Definitions:

a. **Finance and Insurance** - The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:
   a. Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
   b. Pooling of risk by underwriting insurance and annuities.
   c. Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.

b. **Real Estate -** Industries in the Real Estate subsector group establishments that are primarily engaged in renting or leasing real estate to others; managing real estate for others; selling, buying, or renting real estate for others; and providing other real estate related services, such as appraisal services.

c. **Manufacturing** - The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the Manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials-handling equipment. However, establishments that make new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.

d. **Retail Trade** - The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers:
   a. Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
   b. Nonstore retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

e. **Transportation and Public Utilities** - The Transportation and Warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. The Utilities sector comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal.

f. **Agriculture, Forestry, Fishing** - The Agriculture, Forestry, Fishing and Hunting sector comprises establishments primarily engaged in growing crops, raising animals, harvesting timber, and harvesting fish and other animals from a farm, ranch, or their natural habitats. The establishments in this sector are often described as farms, ranches, dairies, greenhouses, nurseries, orchards, or hatcheries.

g. **Professional and Business Services** - The Professional, Scientific, and Technical Services sector comprises establishments that specialize in performing professional, scientific, and technical activities for others. These activities require a high degree of expertise and training. The establishments in this sector specialize according to expertise and provide these services to clients in a variety of industries and, in some cases, to households. Activities performed include: legal advice and representation; accounting, bookkeeping, and payroll services; architectural, engineering, and specialized design services; computer services; consulting services; research services; advertising services;

photographic services; translation and interpretation services; veterinary services; and other professional, scientific, and technical services.

h. **Education and Health Services** - The Educational Services sector comprises establishments that provide instruction and training in a wide variety of subjects. This instruction and training is provided by specialized establishments, such as schools, colleges, universities, and training centers. These establishments may be privately owned and operated for profit or not for profit, or they may be publicly owned and operated. They may also offer food and/or accommodation services to their students. The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities.

i. **Construction** - The construction sector comprises establishments primarily engaged in the construction of buildings or engineering projects (e.g., highways and utility systems). Establishments primarily engaged in the preparation of sites for new construction and establishments primarily engaged in subdividing land for sale as building sites also are included in this sector. Construction work done may include new work, additions, alterations, or maintenance and repairs.

j. **Government** – Civil service employees, often called civil servants or public employees, work in a variety of fields such as teaching, sanitation, health care, management, and administration for the federal, state, or local government. Legislatures establish basic prerequisites for employment such as compliance with minimal age and educational requirements and residency laws.

k. **Natural Resources and Mining** - The Mining sector comprises establishments that extract naturally occurring mineral solids, such as coal and ores; liquid minerals, such as crude petroleum; and gases, such as natural gas. The term mining is used in the broad sense to include quarrying, well operations, beneficiating (e.g., crushing, screening, washing, and flotation), and other preparation customarily performed at the mine site, or as a part of mining activity.

l. **Information Services** - The Information sector comprises establishments engaged in the following processes: (a) producing and distributing information and cultural products, (b) providing the means to transmit or distribute these products as well as data or communications, and (c) processing data.

m. **Wholesale Trade** - TheW holesale Trade sector comprises establishments engaged in wholesaling merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The merchandise described in this sector includes the outputs of agriculture, mining, manufacturing, and certain information industries, such as publishing.

n. **Leisure and Hospitality** - The Arts, Entertainment, and Recreation sector includes a wide range of establishments that operate facilities or provide services to meet varied cultural, entertainment, and recreational interests of their patrons. This sector comprises (1) establishments that are involved in producing, promoting, or participating in live performances, events, or exhibits intended for public viewing; (2) establishments that preserve and exhibit objects and sites of historical, cultural, or educational interest; and (3) establishments that operate facilities or provide services that enable patrons to participate in recreational activities or pursue amusement, hobby, and leisure-time interests. The Accommodation and Food Services sector comprises establishments providing customers with lodging and/or preparing meals, snacks, and beverages for immediate consumption. The sector includes both accommodation and food services establishments because the two activities are often combined at the same establishment.

o. **Other Services** - The Other Services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grantmaking, advocacy,

and providing drycleaning and laundry services, personal care services, death care services, pet care services, photofinishing services, temporary parking services, and dating services.

Patient's Occupation: The occupation of the patient.

Field Value Definitions:

a. **Business and Financial Operations Occupations**
Buyers and Purchasing Agents
Accountants and Auditors
Claims Adjusters, Appraisers, Examiners, and Investigators
Human Resources Workers
Market Research Analysts and Marketing Specialists
Business Operations Specialists, All Other

b. Architecture and Engineering Occupations
Landscape Architects
Surveyors, Cartographers, and Photogrammetrists
Agricultural Engineers
Chemical Engineers
Civil Engineers
Electrical Engineers

c. **Community and Social Services Occupations**
Marriage and Family Therapists
Substance Abuse and Behavioral Disorder Counselors
Healthcare Social Workers
Probation Officers and Correctional Treatment Specialists
Clergy

d. **Education, Training, and Library Occupations**
Engineering and Architecture Teachers, Postsecondary
Math and Computer Teachers, Postsecondary
Nursing Instructors and Teachers, Postsecondary
Law, Criminal Justice, and Social Work Teachers, Postsecondary
Preschool and Kindergarten Teachers
Librarians

e. **Healthcare Practitioners and Technical Occupations**
Dentists, All Other Specialists
Dietitians and Nutritionists
Physicians and Surgeons
Nurse Practitioners
Cardiovascular Technologists and Technicians
Emergency Medical Technicians and Paramedics

f. **Protective Service Occupations**
Firefighters
Police Officers
Animal Control Workers
Security Guards
Lifeguards, Ski Patrol, and Other Recreational Protective Service

g. **Building and Grounds Cleaning and Maintenance**
Building Cleaning Workers
Landscaping and Groundskeeping Workers Pest Control Workers
Pesticide Handlers, Sprayers, and Applicators, Vegetation
Tree Trimmers and Pruners

h. **Sales and Related Occupations**

Advertising Sales Agents
Retail Salespersons
Counter and Rental Clerks
Door-to-Door Sales Workers, News and Street Vendors, and Related Workers
Real Estate Brokers

i. **Farming, Fishing, and Forestry Occupations**
Animal Breeders
Fishers and Related Fishing Workers
Agricultural Equipment Operators Hunters and Trappers
Forest and Conservation Workers
Logging Workers

j. **Installation, Maintenance, and Repair Occupations**
Electric Motor, Power Tool, and Related Repairers
Aircraft Mechanics and Service Technicians
Automotive Glass Installers and Repairers
Heating, Air Conditioning, and Refrigeration Mechanics and Installers
Maintenance Workers, Machinery
Industrial Machinery Installation, Repair, and Maintenance Workers

k. **Transportation and Material Moving Occupations**
Rail Transportation Workers, All Other
Subway and Streetcar Operators
Packers and Packagers, Hand
Refuse and Recyclable Material Collectors
Material Moving Workers, All Other
Driver/Sales Workers

l. **Management Occupations**
Public Relations and Fundraising Managers
Marketing and Sales Managers
Administrative Services Managers
Transportation, Storage, and Distribution Managers
Transportation, Storage, and Distribution Managers
Food Service Managers

m. **Computer and Mathematical Occupations**
Web Developers
Software Developers and Programmers
Database Administrators
Statisticians
Computer Occupations, All Other

n. **Life, Physical, and Social Science Occupations**
Psychologists Economists Foresters
Zoologists and Wildlife Biologists
Political Scientists
Agricultural and Food Science Technicians

o. **Legal Occupations**
Lawyers and Judicial Law Clerks
Paralegals and Legal Assistants
Court Reporters
Administrative Law Judges, Adjudicators, and Hearing Officers
Arbitrators, Mediators, and Conciliators
Title Examiners, Abstractors, and Searchers

p. **Arts, Design, Entertainment, Sports, and Media**
Artists and Related Workers, All Other
Athletes, Coaches, Umpires, and Related Workers
Dancers and Choreographers Reporters and Correspondents

Interpreters and Translators
Photographers

q. **Healthcare Support Occupations**
Nursing, Psychiatric, and Home Health Aides
Physical Therapist Assistants and Aides
Veterinary Assistants and Laboratory Animal Caretakers
Healthcare Support Workers, All Other
Medical Assistants

r. **Food Preparation and Serving Related**
Bartenders
Cooks, Institution and Cafeteria
Cooks, Fast Food
Counter Attendants, Cafeteria, Food Concession, and Coffee Shop
Waiters and Waitresses
Dishwashers

s. **Personal Care and Service Occupations**
Animal Trainers
Amusement and Recreation Attendants
Barbers, Hairdressers, Hairstylists and Cosmetologists
Baggage Porters, Bellhops, and Concierges
Tour Guides and Escorts
Recreation and Fitness Workers

t. **Office and Administrative Support Occupations**
Bill and Account Collectors
Gaming Cage Workers
Payroll and Timekeeping Clerks
Tellers
Court, Municipal, and License Clerks
Hotel, Motel, and Resort Desk Clerks

u. **Construction and Extraction Occupations**
Brickmasons, Blockmasons, and Stonemasons
Carpet, Floor, and Tile Installers and Finishers
Construction Laborers
Electricians
Pipelayers, Plumbers, Pipefitters, and Steamfitters
Roofers

v. **Production Occupations**
Electrical, Electronics, and Electromechanical Assemblers
Engine and Other Machine Assemblers
Structural Metal Fabricators and Fitters
Butchers and Meat Cutters
Machine Tool Cutting Setters, Operators, and Tenders, Metal and Plastic
Welding, Soldering, and Brazing Workers

w. **Military Specific Occupations**
Air Crew Officers
Armored Assault Vehicle Officers
Artillery and Missile Officers
Infantry Officers
Military Officer Special and Tactical Operations Leaders, All Other

Foreign Visitor is defined as any person visiting a country other than his/her usual place of residence for any reason.

Intermediate care facility: A facility providing a level of medical care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide but greater than the level of room and board.

Home Health Service: A certified service approved to provide care received at home as part-time skilled nursing care, speech therapy, physical or occupational therapy or part-time services of home health aides.

Homeless: is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.

Hospice: An organization which is primarily designed to provide pain relief, symptom management and supportive services for the terminally ill and their families.

Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.

Operative and/or essential procedures is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries. Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).

Skilled Nursing Care: Daily nursing and rehabilitative care that is performed only by or under the supervision of skilled professional or technical personnel. Skilled care includes administering medication, medical diagnosis and minor surgery.

Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission.

Appendix 4: NTDS References

National Trauma Data Standard (NTDS) Data Dictionary

Content for the NTDS can be found at: http://www.ntdsdictionary.org/.

The following information should be reviewed before submitting data to the NTDB or Indiana Trauma Registry:

1. Appendix 1: NTDB Facility Dataset (pages A1.1 – A1.3 of the 2015 NTDS Data Dictionary)
2. Appendix 2: Edit Checks for the National Trauma Data Standard Data Elements (pages A2.2 – A2.32 of the 2015 NTDS Data Dictionary)
3. Appendix 3: Glossary of Terms (pages A3.1 – A3.12 of the 2015 NTDS Data Dictionary)

Appendix 4: Maps

Indiana Hospitals